MEDICATION ADMINISTRATION AUTHORIZATION FORM

Student's Name ____ DOB __________________

Teacher/Advisor ______________________________________

School ____Grade _________________

Name of Medication ____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Diagnosis/Condition ____

Dose, Route other Administration Instructions ____

Frequency & Time(s) to be given at school ____

Dates to be given_______________20__/20__ school year or __________________________

Optional:
If an AM dose is given at home and is omitted, a dose of ________mg may be given at school after omission is verified by a parent/guardian. School dose may then be given ________ hours later.

Special Side Effects, Adverse Reactions or Contraindications ___________________________

____

____

Additional information____

Licensed Prescriber Signature____________________________ Date______________________

Licensed Prescriber Telephone Number ____

PARENT/GUARDIAN AUTHORIZATION

PLEASE LIST ALL MEDICATION THE CHILD IS TAKING AT HOME (Prescription and over the counter medications) if not a violation of confidentiality

1.____2.____________________________________

3.____4.____________________________________

I hereby authorize the designated staff person or school nurse to administer the above medication as directed. In consideration for this service, I further agree that I will not hold liable, and will otherwise save harmless, the District and/or any department or employee thereof for death or

injury resulting from administration or assistance in the administration of the medication described above. I understand that (a) not more than one month of prescribed medicine may be stored in school, (b) medication will be delivered directly to the School Nurse, Principal or designated staff member by the parent or guardian, if possible, and (c) the medication will be delivered in a container properly labeled with the student's name, the physician's name, the date of original prescription, name and strength of medication and directions for taking by the student.

Printed Name of parent/guardian ____

Signature of parent/guardian________________________________ Date___________________

Yes No I give my permission for release/exchange of pertinent information by telephone, mail or electronic exchange including fax or e-mail between the school nurse and the physician's office regarding the above medication.

Yes No I give my permission for other school personnel to be notified of the medication and any adverse effects.

Signature of parent/guardian_______________________________ Date____________________

SAU Policy Committee: Adopted – October 15, 2020

Clarksville School Board: Adopted – December 14, 2020
Colebrook School Board: Adopted – December 15, 2021
Columbia School Board: Adopted – January 6, 2021
Pittsburg School Board: Adopted – December 1, 2020
Stewartstown School Board: Adopted – January 12, 2021