ST. JOHN REGIONAL CATHOLIC SCHOOL

MEDICATION AUTHORIZATION FORM

This order is valid only for the current school year____________________

OR

Start Date: ____/____/_____ to Stop Date: _____/____/____

A new medication administration form must be completed at the beginning of each school year, for each medication and each time there is a change in dosage, or time of administration of a medication.

•This medication form must be completed fully in order for staff to administer required medication.

Name:	*Date of Birth:*	*Grade:*

HEALTH CARE PROVIDER AUTHORIZATION

Allergies:

Condition for which medication is being administered:

Type:	Dose:	Route:
Name of Medication:______________________________	☐ _______mg ☐ 2 puffs ☐ _______	☐ Oral ☐ Inhalation ☐ Other______________

Time of Administration:	*If PRN, frequency:*

Additional Instructions:

Specific Instructions for Inhaler:

Administer inhaler for symptoms such as: *coughing, audible wheezing, complaint of tightness in chest, complaint of shortness of breath, or other* ____.

Is student competent to self-carry medication? ☐ Yes ☐ No	**Is student competent to self-administer medication?** ☐ Yes ☐ No

Possible Medication Side Effects:
☐ None expected Specify: ______________________________

Health Care Provider's Name/Title: (Please Print)

Telephone: Fax:

Address:

Health Care Provider Stamp

Health Care Provider's Signature: *Date:*

PARENT/GUARDIAN AUTHORIZATION

I request designated personnel to administer the medication as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of medication at school and understand that the health care provider will be contacted if questions arise regarding the student's medication order.

Primary Contact Phone:	*2nd Phone:*

Parent/Guardian Signature: *Date:*

REGISTERED NURSE REVIEW / AUTHORIZATION

Is student competent to self-carry medication? ☐ Yes ☐ No	*Is student competent to self-administer medication?* ☐ Yes ☐ No

RN Signature: *Date:*