# AUTHORIZATION FOR MEDICATION OR TREATMENT

This order is valid only for school year (current) _____ including the summer session.

School: _____

**This form must be completed fully in order for schools to administer the required medication. 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.**

* Prescription medication must be in a container labeled by the pharmacist or prescriber.

*Non-prescription medication must be in the original container with the label intact.

*An adult must bring the medication to the school.

*The school nurse will call the prescriber, as allowed by HIPPA, if a question arises about the child and/or the child's medication.

## Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN for what symptoms: _____

Relevant side effects: ☐ None expected ☐ specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____
(Type or Print)

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____
(Original Signature Only)

(Use for Prescriber's Address Stamp)

## PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.

I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian:_____ Date: _____

| _____ | _____ | _____ |
|---|---|---|
| Home Phone # | Cell Phone # | Work Phone # |

## SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of medication (including emergency medication) may be authorized by the prescriber and parent/guardian and must be approved by the school nurse according to the school medication policy.

Prescriber's authorization for self-carry/self-administration of medication: _____
Signature/Date

Parent/Guardian authorization for self-carry/self-administration of medication: _____
Signature/Date

School Nurse approval for self-carry/self-administration of medication: _____
Signature/Date

Rogers City Elementary School Fax: 989-734-9165
Rogers City Middle & High School Fax: 989-734-2969

10/2/18