WHITMAN
HANSON

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

STUDENT INFORMATION:

Name: ______________________________ DOB: ________ School: __________________________

Parent/Guardian(s):______________________________Address:______________________________

Home#:______________ Cell#'s:__________________________ Work #'s:______________________

Emergency Contact (Name/Number): ____

This section to be filled out by a licensed prescriber

Name of Licensed Prescriber: __________________________________ Phone: ________________

Medication to be administered: ________________________________ Dose/Route: ________________

Time/Frequency/Instructions: ____

*Diagnosis: ____________________ Date of order: _____________ Discontinuation Date: ____________

Allergies: ____________________ Possible Side Effects: _____________________________________

*Other medications taken by student: ____

Consent for self-administration: Yes ___ No ___ (provided school nurse determines it is safe and appropriate)

Prescriber Signature: ____ Date: _____________________

(*If not in violation of confidentiality)

PARENT CONSENT:

I request that my child ____________________ receive the prescribed medication as listed above. I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety. I understand I may retrieve the medication from the school at any time; however, any medication left in the health office at the end of the school year will be disposed of. *Whenever possible, medication should be scheduled to be given at home.*

- Prescription medication must be in a container labeled by the pharmacy
- Non –prescription medication must be in the original container with label intact
- An adult must bring the medication to school to give to the school nurse
- State regulations allow students to carry and self-administer medication provided certain conditions are met. Please consult with your school nurse.

Parent/Guardian Signature: ______________________________________ Date: ___________________

- ➢ Order reviewed by school nurse:
  Nurse signature: ____ Date: ___________________