Northview Public Schools

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) **2023/2024**

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.

* **All medications must be brought to school and picked up prior to the last day of school by a parent or guardian.**
* 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.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

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

Allergies _____ Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If taken as needed, for what symptoms: _____

_____

Restrictions and/or side effects: □ None expected □ Specify: _____

PRESCRIBER'S AUTHORIZATION

(For prescription medication only)

Prescriber's Name/Title: _____

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp 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 Signature: _____ Date: _____

Home/Cell Phone #: _____ Work Phone #: _____

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

Self-carry/self-administration of medication (**only emergency medication**) may be authorized by the prescriber and must be approved by the school nurse according to the School Nurse Program medication policy.

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

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

Order reviewed by the school RN: _____ _____