



## MEDICATION AUTHORIZATION

*Building Bridges to the Future*

Medication should be ordered to be given to a student at school ONLY WHEN ABSOLUTELY NECESSARY. Whenever possible, the parent and Licensed Health Care Provider are urged to design a schedule for giving medication outside of school hours. If this is not possible, the medication will be dispensed by designated school personnel. Prescription medication is to be furnished in the original container, labeled with the name of the medication, the amount to be taken, frequency of administration, the name of the physician, and the name of the child. Over the counter medication is to be furnished in the original unopened container with label, directions, and expiration date clearly legible. This authorization is good for the current school year only. Unused medication should be collected from the school. Any uncollected medication will be destroyed at the end of the year or at the end of the prescribed duration of administration, whichever is sooner. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the Licensed Health Care Providers directions.

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Other Phone : \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ONE MEDICATION PER SHEET PLEASE

**This section to be completed by the Licensed Health Care Provider**

Medication to be administered: \_\_\_\_\_

Dosage and mode of administration: \_\_\_\_\_

Time to be administered: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Possible side effects of medication: \_\_\_\_\_

Dates for administering medication: \_\_\_\_\_ Current School Year \_\_\_\_\_ Other: \_\_\_\_\_

Special storage requirements: \_\_\_\_\_ None \_\_\_\_\_ Refrigerate \_\_\_\_\_ Other: \_\_\_\_\_

Student may self-administer: \_\_\_\_\_ Yes \_\_\_\_\_ No Student has demonstrated safe and appropriate self-administration: \_\_\_\_\_

**Licensed Health Care Provider:** Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Fax: \_\_\_\_\_

**School Nurse Review:** Date Received: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Expiration: \_\_\_\_\_ Signature: \_\_\_\_\_ Notes: \_\_\_\_\_