Authorization for Administration of Medication

Section 1. To be completed by parent/guardian

STUDENT INFORMATION

Name DOB / / Grade Teacher

CONTACT INFORMATION

Parent/Guardian Phone Cell

Section 2. Please fill out for all medication. Over-the-counter medications only need parent signature in section 3.

MEDICATION INFORMATION

Medication Dosage Route Frequency

Effective date End date Possible side effects

Diagnosis ICD-10#

X

Signature of Practitioner Licensed to Prescribe*

Licensed Practitioner (printed name) Clinic Office Fax

** Required for prescription medications and for over-the-counter medications that exceed package recommendations.*

NOTE: Medication must be in original prescription bottle or packaging.

Section 3. To be completed by parent/guardian for staff administration of medication.

STAFF ADMINISTRATION OF MEDICATION AUTHORIZATION

1. I request that the above medication be given to my student during school hours.
2. I will immediately notify the school of any change in the medication or licensed practitioner's order, dosage change, frequency, or duration of administration.
3. The prescribing Health Care Provider (HCP) may release information to and/or request information from RPS professional staff related to the authorized medication order.
4. RPS professional staff may release information to and/or request information from the prescribing HCP related to the authorized medication order.
5. Legally, you may refuse to sign for the medication at school. If you refuse, we will not be able to administer the medication.
6. I would like to have this medication administered on a field trip, as necessary: ☐ Yes ☐ No

X

Signature of Parent/Guardian **Date**

Section 4. (Grades 7-12 only) To be completed by parent/guardian and student ONLY if the medication will be self-carried and self-administered by the student. Students in 7-12 will only be allowed to carry epi-pens and inhalers. All other prescription medication needs to be keep in the nursing office.

SELF-ADMINISTRATION AND SELF-CARRY OF MEDICATION AUTHORIZATION

I agree to:

- ☐ Follow my HCP's medication orders
- ☐ Use correct medication administration technique
- ☐ Not allow anyone else to use my medication
- ☐ Keep a supply of my medication with me in school and on field trips
- ☐ Notify the school nurse or health office personnel if the following occurs:
  - My symptoms continue or worsen after taking my medication
  - My symptoms reoccur within 2-3 hours after taking my medication
  - I suspect that I am experiencing side effects from my medication
  - I have any symptoms of an allergic reaction

Signature of Student **Date** / /

I hereby authorize my student to self-administer the above-named medication during school hours. I understand my student will carry this medication at school. I also understand my student is entirely responsible for the use of this medication and use of this medication will not be monitored at school.

Signature of Parent **Date** / /

The student has demonstrated knowledge about and proper use of his/her medication.

Signature of Health Office Staff **Date** / /