

# MULTIPLE MEDICATION ADMINISTRATION AUTHORIZATION

STUDENT: _____	SCHOOL: _____	GRADE: _____	DOB: _____
ADDRESS: _____		STATE: _____	ZIP: _____

MEDICAL HISTORY: \_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

**TO BE FILLED OUT OR REVIEWED BY THE PRESCRIBING PRACTITIONER:**

MEDICATION: _____  Dose: _____ Time _____  Route: <input type="checkbox"/> Oral <input type="checkbox"/> Inhalant <input type="checkbox"/> Injection <input type="checkbox"/> Nasogastric Tube <input type="checkbox"/> Gastrostomy Tube <input type="checkbox"/> Other _____  Reason for medication _____ Can child self-administer this medication? _____ Is medication needed in his/her possession? _____ Potential adverse side effects: _____ Refrigeration Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	MEDICATION: _____  Dose: _____ Time _____  Route: <input type="checkbox"/> Oral <input type="checkbox"/> Inhalant <input type="checkbox"/> Injection <input type="checkbox"/> Nasogastric Tube <input type="checkbox"/> Gastrostomy Tube <input type="checkbox"/> Other _____  Reason for medication _____ Can child self-administer this medication? _____ Is medication needed in his/her possession? _____ Potential adverse side effects: _____ Refrigeration Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
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**PRESCRIBING PRACTITIONER AUTHORIZATION:** *I have determined that the above described medications and routes of administration are medically necessary during school hours to maintain this child's physical health.*

**Prescribing Practitioner's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Office Phone** \_\_\_\_\_ **FAX** \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION:** *The school authorized personnel have my permission to administer the above medication. I will adhere to the following conditions of this agreement:*

- I will bring this form into the office completed and signed by my health care practitioner before expecting medication to be administered.
- I will bring the medication to school in its original pharmacy-labeled container (or manufacturer's container if over-the-counter), and I will maintain the supplies as needed throughout the year, or until discontinued.
- I will renew this authorization every time there is a change of any kind regarding the medication, the information in this form, and/or the pharmacy label.
- I will pick up the unused medication when it has been discontinued, and at the end of the school year. If I do not pick it up within 5 days I will allow the authorized personnel to dispose of it.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Home Phone** \_\_\_\_\_ **Emergency phone** \_\_\_\_\_