Washington County School District Health Services

MEDICATION ADMINISTRATION AUTHORIZATION

STUDENT:	SCHOOL:	GRADE:	DOB:
ADDRESS:		STATE:	ZIP:
MEDICAL HISTORY:			

TO BE FILLED OUT OR REVIEWED BY THE PRESCRIBING PRACTITIONER:

Medication: _____ Dose: _____ Time: _____

Route: Oral____ Inhalant____ Injection____ Nasogastric Tube____ Gastrostomy Tube____

Other_____ Refrigeration needed: YES_____ NO_____

Is this child qualified & able to self-administer this medication? * YES _____ NO _____

Does this child need to have this medication in his/her possession? * YES _____ NO _____

Reason for medication:_____

Potential adverse side effects:_____

Known Allergies to medications:_____

Medical History: _____

_____

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.*

Comments: _____

_____

Practitioner Signature:_____ **Date:**_____

Office Phone: _____ **Fax Number:** _____

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

1. I will bring this form into the office completed and signed by my health practitioner before expecting medication to be administered;
2. 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;
3. I will renew this authorization every time there is a change of any kind regarding the medication, the information on this form, and/or the pharmacy label.
4. 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:**_____