

# 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:** \_\_\_\_\_