ST JOSEPH MARQUETTE SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) ___________________ including the summer session.

BOTH PRESCRIPTION AND NON-PRECRIPTION MEDICATIONS MUST FOLLOW THIS POLICY AS MANDATED BY STATE LAW.

* This form must be completed fully in order for schools to administer the required medication.
* A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.
* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school CSN/RN will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.
* Whenever possible, the parent will design a schedule for giving medication outside of school hours.

Prescriber's Authorization

Name of Student: ____ DOB: ____________________ Grade: _____________________

Condition for which medication is being administered: ____

Medication Name: ____ Dose: ____________________ Route: ____________

Time/frequency of administration: ____ If PRN, frequency: __________________________

If PRN, for what symptoms: ____

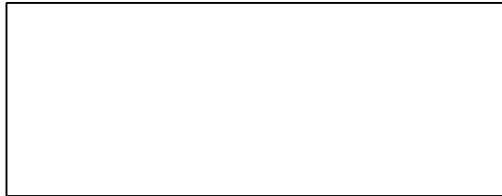
Relevant side effects: _______None expected ________ Specify: ____

Medication shall be administered from: ____________________________________ to ____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: ____
(Type or print)
Telephone: _________________________ FAX: _______________________

Address: ____

____



Prescriber's Signature: __________________________ Date: ____________
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the CSN/RN (Name): ________________________________ for the above mediation on (Date): ___________

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: ____ Date: ____________________________

Home Phone #: _________________________________ Cell Phone #: ______________________________ Work Phone#: _________________________

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: ____
Signature Date

CSN/RN approval for self carry/self administration of emergency medication: ____
Signature Date

Order reviewed by the CSN/RN: ____
Signature Date

THE SCHOOL ACCEPTS NO RESPONSIBILITY FOR UNTOWARD REACTIONS WHEN THE MEDICATON IS DISPENSED IN ACCORDANCE WITH THE PHYSICIAN'S ORDERS.