SCHOOL OF SCIENCE & TECHNOLOGY
Better Education, Better Future

SST SCHOOLS
MEDICATION ADMINISTRATION AUTHORIZATION FORM

For office use only:
ROUTINE: ☐
PRN: ☐

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

School: _____

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.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ 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)

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 acknowledge that I/we have read, understand, and agree to comply with the medication administration procedures and requirements outlined in the Student-Parent Handbook. I/We authorize the school health aide to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date:_____

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

School admin approval for self carry/self administration of emergency medication: _____

Order reviewed by the school: _____ Signature _____ Date _____