Saint Alphonsus
SCHOOL HEALTH PROGRAM

School Medication Administration Authorization Form

This order is valid only for school year (current) _____ School: _____

This form must be completed in full for the school nurse and staff to administer the required medication. A new form must be completed at the beginning of each school year and whenever 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.**
*** A parent/guardian must bring all controlled substances directly to the school nurse.**

Name of Student: _____ Date of Birth: _____Grade: _____

Medication Name	Route	Dosage and Frequency	Reason for administration	Special Instruction / Side effects

Prescriber's Name/Title:_____Telephone:_____

PARENT/GUARDIAN AUTHORIZATION

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

Parent /Guardian Signature:_____ Date:_____

Cell Phone: _____ Work Phone:_____

Order Reviewed by the School Nurse:_____ Date:_____