

MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form is only valid for 2020-2021 school year

- * This form is required for all medication, including non-prescription (over-the-counter) medication.
- * No prescription medication will be administered without both the prescriber's and the parent/guardian's signatures.
 - f * Over-the-Counter medication will be administered with parent/guardian's signature
 - * A separate authorization form is required for **each** medication.

A new authorization form must be completed any time there is a change in a medication's strength or time of administration, and at the beginning of each school year.

PRESCRIBER'S AUTHORIZATION AND ORDER	
Name of Student:	Date of Birth:
Medication Name:	Strength/Dose:
Frequency:	PRN?yesno Route:
Circle time(s) of day medication is	o be administered at school: 8am 9am 10am 11am 12pm 1pm 2pm 3pm
Diagnosis or reason for medication	
Significant potential side effects:	none expected 🗆 specify:
Medication shall be administered f	om:to:
	(Month / Day / Year) (Month / Day / Year)
If this medication is an asthma inha	ler, epinephrine auto-injector, or other emergency medication, is student
authorized to self-carry/self-adminis	ter? yes no
Special Instructions:	
Prescriber's Name/Title:	Phone:
Prescriber's Signature:	Fax:
authority to consent to medical treatm	• & AUTHORIZATION: o administer the medication as prescribed by the above prescriber. I certify that I have legal ent for the student named above, including the administration of medication at school. Date:
Home/Cell Phone #:	Work #: Email:

- *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 school.
- *Medication must be picked up at the end of the school year or it would be DISCARDED