Worcester County Public Schools
School Medication Administration Authorization Form

This order is valid only for the current school year _____, 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 must be in the original container with the label intact.
- An adult must bring the medication to the school.
- The school nurse (RN) will call the prescriber, as allowed by HIPPA, if a question arises about the child and/or the child's medication.

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 _____
MM/DD/YY MM/DD/YY

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 school RN: _____ for the above medication on _____.
Name Date

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the mediation 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

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school RN: _____
Signature Date