

**ESKO PUBLIC SCHOOLS  
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM**

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

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be complete 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 label intact**.
- \* An adult **MUST** bring medication to school unless agreed upon by both parent and school nurse (see box below)
- \* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child's medication

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Condition for which the medication is being administered for: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time/frequency of administration: \_\_\_\_\_

If PRN, for what symptoms: \_\_\_\_\_

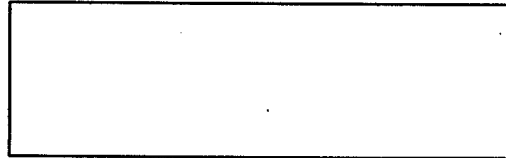
Relevant side effects: ☐ None expected ☐ Specify: \_\_\_\_\_

Prescriber Name/Title: \_\_\_\_\_

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 nurse for the above medication 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 the school. I/We understand that at the end of the school year, an adult must pick up the medication, unless authorized below.

\_\_\_\_ I/We authorize the student to transport medication to and from school as required.

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 parents and/or legal guardians and must be approved by the school nurse.

Parent authorization for self-carry/self-administration of emergency medication: \_\_\_\_\_

School RN approval for self-carry/self-administration of emergency medication: \_\_\_\_\_

Order reviewed by the school RN: \_\_\_\_\_  
Signature Date