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

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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 mediation 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: _____
Signature *Date*

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

Order reviewed by the school RN: _____
Signature *Date*