Ashe County Schools
School Medication Administration Authorization Form

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 medication administration.

- 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.
- The school nurse (RN) will call the prescriber, as allowed by HIPPAA, if a question arises about the child and/or the child's medication.

School : _____ This order is valid only for school year (current) _____including the summer session.

Physician'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_____

Month/Day/Year *Month/Day/Year*

Provider's Name/Title: _____

Type or Print

Telephone: _____Fax: _____

Address: _____

_____

Provider's Signature: _____Date: _____

(*Original signature or signature stamp only)*

(Use for Provider's Address Stamp)

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 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 HIPPA.

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 nurse approval for self-carry/self administration of emergency medication: _____

Signature *Date*

Order reviewed by the school nurse: _____