South Harrison Community School Corporation

Medication Authorization/Administration Form

Guidelines:

1. All medication, both prescription and non-prescription, to be used during the school day must be given to the school nurse or her designee at the start of the school day.
2. This form must accompany the medication and must be completed and signed by a parent/guardian and the health care provider (physician, dentist, or nurse practitioner). **A form must be completed for each medication**.
3. A new form must be completed each new school year and each medication must be on its own form.
4. All medications must be kept in the original container. Prescription medication must be in a pharmacy bottle labeled correctly with the dosage and times to give matching the physician's order on this form. The student's name must be on the bottle.
5. **Any change in medication, dosage, or time to be given must be given in written form with the parent and health care provider's signature.**
6. Medications are kept under lock and key and are dispensed by the school nurse or her designee unless the physician has ordered it to be self-administered.
7. Parents must pick up remaining medication within one week of termination of an order or on the last day of the school year or the medication will be destroyed in the presence of a witness.

Student: _____Date of Birth: _____

TO BE COMPLETED BY THE PHYSICIAN:

Medication to be given:_____

Dosage to be given:_____

Time of day to be given:_____

Condition being given for:_____

Start Date: _____ **Stop Date**: [] End of School Year [] Other _____

Special Instructions:

[] This medication is to be self-administered by the student. He/she has been instructed on how to self-administer the medication.

[] Please observe for the following adverse reactions: _____

_____

[] Other _____

_____

Physician's Signature: _____ Date:_____

Physician's Printed Name: _____

Physician's Phone Number: _____

Physician's Address/City/State/Zip: _____

TO BE COMPLETED BY THE PARENT:

I request, authorize, and give permission for the above named student to receive this medication during the school day as indicated. I authorize school personnel to exchange information regarding this medication with the health care provider listed above and/or the dispensing pharmacy.

Parent/Legal Guardian Signature:_____ Date:_____