

School Medication Administration Authorization Form

This order is valid only for school year (current) School:					
medication administr	ration fo	orm must be comple		e required medication. A new each school year, and each on.	
•	edicatio	n must be in the orig	abeled by the pharmaci inal container with the ol.	•	
Name of Student:			Date of Birth:	Grade:	
Medication Name	Route	Dosage and Frequency	Reason for administration	Special Instruction / Side effects	
Prescriber's Name/Tit	tle:		Telephone:_		
		PARENT/GUARD	IAN AUTHORIZATION		
provider. I/We certify named above, includi the school year, an ac and will comply with	that I/V ng the a dult mus the scho	pol personnel to adm Ve have legal author dministration of med t pick up the medica ool medication policy	inister the medication a ity to consent to medica dication at school. I/We tion, otherwise it will be	as prescribed by the above all treatment for the student understand that at the end of e discarded. I/We have read site). I/We authorized the HIPAA.	
				Date:	
Cell Phone:		Home Phone:_	Wo	Work Phone:	
Order Reviewed by t	he Schoo	ol Nurse:		Date:	