Medication Authorization Form

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name:_____ Grade_____ Date of Birth:_____

School:_____School Year:_____

♦♦♦PLEASE USE A SEPARATE FORM FOR EACH MEDICATION♦♦♦

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of medication:_____Allergies:_____
Reason for medication:_____
Form of medication/treatment:
□ Tablet/Capsule □ Liquid □ Inhaler □ Injection □ Nebulizer □Other_____
Instructions (Time to be given at school):_____
Dose (mg, ml, ml/tsp, #puffs)_____
If PRN, for what symptom(s)_____
Side effects: (Please describe)_____
Please check one of the following:
Discontinue: □ End of school year □Other (specify):_____

♦♦♦Please note: Any deviation from the scheduled time requires a new order.♦♦♦
This includes delayed openings, early dismissals or field trips.

Authorized Prescriber's Signature:_____Date:_____
Authorized Prescriber's Name/Title:_____Phone:_____Fax:_____

A verbal order was taken by the School Nurse (name)_____for the above medication on (date)_____
Verbal order must be followed by a signed order within 3 days.

♦♦♦For Self-Administration ONLY♦♦♦For Self-Administration ONLY♦♦♦

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

TO BE COMPLETED FOR EMERGENCY MEDICATION (e.g. Inhaler, Epipen) ONLY

Greencastle-Antrim Board of Education permits a student to possess and self-administer emergency medication at school and at school-related functions. Completion of the following information by the authorized prescriber acknowledges that this student has been instructed and has the skills and knowledge on self-administration of this medication.

This student may carry this medication: □ No □ Yes
Signature:_____Date_____
__
(Authorized Prescriber's Signature)

♦♦♦PARENT TO COMPLETE EMERGENCY MEDICATION CONTRACT ON BACK OF THIS FORM♦♦♦

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to standard school policy. I release the Greencastle-Antrim Board of Education and their employees from any claim or liability for administering prescribed medication to this student. **I HAVE READ THE INFORMATION OUTLINED ON THE BACK OF THIS FORM AND ASSUME THE RESPONSIBILITIES AS STATED ON THIS FORM.** I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Date:_____Signature:_____Relationship:_____

Home phone:_____Work phone:_____Emergency phone:_____

Order reviewed by the school RN_____Date_____

MEDICATION GUIDELINES

The following medication guidelines are used by the Greencastle-Antrim School District. These guidelines enable the school health staff to provide the best possible service to your child.

1. Whenever possible, medication should be given at home.

2. The first dose of all new medication must be administered at home.

3. In order for any prescription or over-the-counter medication, to be given at school, the medication must be accompanied by the completed medication Authorization Form (see reverse side).

4. The school nurse will call the prescriber as allowed by HIPAA if a question arises about child and/or child's medication.

5. All prescription medication must be in the original pharmacist labeled container. Non-prescription medication must be in the original sealed container with the label intact. It is also important to make sure the bottle has a current expiration date on it. **Staff may not dispense outdated medication.**

6. A parent/guardian or another responsible adult must bring any medication to the nursing office.

7. All medications are kept in the Health Office. The health staff will attempt to notify parents/guardians in advance when your child's medication supply is getting low.

8. If your child takes medication in the morning at home, it is important to give it at the same time every day. If your child is coming to school late due to an appointment or a delayed school opening, the morning dose should be given as usual because the school dose will be given at the time ordered. **Any deviation from the scheduled time requires a new order.**

9. Antibiotics that are given three times a day are not usually given at school. Please consult your physician before bringing these medications to school.

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION CONTRACT

This section must be completed in addition to the Medication Administration Form (see reverse side) for those students who need to carry medication in order to self administer in an emergency.

1. Student has demonstrated the purpose and the appropriate method and time to administer the emergency medication to the nurse.

2. Student agrees to never share the emergency medication with another student.

For Epipen medication:

a. Student agrees to inform nurse after administering an Epipen.

For Asthma medication:

a. Student agrees that after two puffs, if there is not marked improvement, he/she will go to the health office.
b. It is advisable that a spare inhaler be kept in the health office.

Permission to self-administer may be withdrawn and the student may be subject to disciplinary action if he/she does not use the medication in a safe and proper manner.

_____ _____
Student Signature Date

_____ _____
Nurse Signature Date

_____ _____
Administrator Signature Date

I give permission for my child_____ to carry the emergency medication as prescribed by the physician. I understand that he/she must follow the rules listed above. I will notify the school nurse of changes in medication or my child's condition.

_____ _____
Parent's Signature(s) Date

_____ _____
Parent's Signature(s) Date