Coopersville Area Public Schools
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

This form must be completed for any medications prescribed by a physician and any over-the-counter (OTC) drugs, preparations, and/or remedies. The 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 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 the medication to the school.
- The school RN will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or child's medication.

Name of student: _____ Date of Birth: _____ Grade: _____

PRESCRIBER'S AUTHORIZATION

(To be completed by the Physician)

Condition for which medication is being administered: _____

Medication Name: _____ Dose:_____

Medication shall be administered from: (_____/_____/_____) to (_____/_____/_____)

Route: ☐ Oral ☐ Injection ☐ Intranasal ☐ Nebulizer ☐ Topical ☐ Rectal Storage: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms:_____

Relevant side effects: ☐ None expected ☐ Specify: _____

Prescriber's Name/Title _____

Telephone: _____ Fax: _____

Address:_____

_____

Prescriber's Signature:_____

Date: _____ (Original Signature or Signature Stamp Only)

(Use for Prescriber's Address Stamp)

SELF POSSESSION /SELF ADMINISTRATION OF MEDICATION AUTHORIZATION AND APPROVAL

Self possession/self administration of **emergency medication** may be authorized by the prescriber, and must be reviewed by the school nurse or school administration staff according to the School Nurse Program medication policy.

This student is capable and responsible for self-administering this medication: ☐ Yes – supervised ☐ Yes – unsupervised ☐ No

This student may carry this medication: ☐ Yes ☐ No

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 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 HIPAA.

Parent/Guardian Name: _____ Phone #: _____

Parent/Guardian Signature: _____ Date: _____

Order reviewed by the school RN or office administration: _____

Signature Date