Clovis Municipal Schools

CLOVIS MUNICIPAL SCHOOLS **GEN 588**

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

School: _____ Grade: _____

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 to be administered, 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 the label intact.
- An authorized adult must bring the medication to the school.
- An authorized adult must pick up the medication at the end of the prescribing period or it will be discarded.
- The school nurse will share information relevant to the prescribed medication as he/she determines to be appropriate for your child's health and safety. The school nurse will also call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

PRESCRIBER'S AUTHORIZATION

Student Name: _____ 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

Prescriber's Name/Title_____ Telephone: _____

Fax: _____ Address: _____

Prescriber's Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed and as instructed 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 agree to furnish the necessary medication in a pharmacy/original labeled container; to provide replacement medication as necessary; and to provide a new authorization form if there is ANY change in the medication, dosage, administration time, administration route, or special instructions regarding the medication. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE:

Medication received by _____
(Signature of School Personnel Receiving the Medication) Date

Action Plan/Self-Carry Forms received: ☐ YES ☐ NO

Medication and Authorization Reviewed by RN: _____
Signature Date