Watauga County Schools
School Medication Administration Authorization Form

School_____

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, 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.
- A parent/guardian must bring the medication to school.
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

(To be completed by the physician)

Name of Student:_____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:_____
(Type or Print)
Telephone:_____FAX:_____

Address:_____

Prescriber's Signature:_____Date:_____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

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 the administration of medication at school. I/we understand tat at the end of the school year, an adult must pick up the medication or it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian Signature:_____Date:_____

Home Phone #:_____Cell Phone #:_____Work Phone #:_____

Self Carry/Self Administration of Emergency Medication Authorization/Approval

Self-carry/self-administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to policy.

Prescriber's authorization for self carry/self administration of emergency medication:_____
Signature Date

School RN approval for self carry/self administration of emergency medication:_____
Signature Date

Order reviewed by the school nurse (RN):_____
Signature Date