# Medication Administration Authorization
## Addison Community Schools 2024-25

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 (OTC) medication must be in the original container with the 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 the child's medication.

**Student Name**: _____ **Date of Birth**: _____

Grade: _____ Teacher: _____ Allergies: _____

**TO BE COMPLETED BY THE LICENSED PROVIDER (MD, DO, NP, PA, Dentist):**

**Medication #1**: _____

Dose of Medication: _____ Route: _____

Time/Frequency of Medication: _____ If PRN, frequency: _____

Relevant Side Effects: _____ None Expected: _____ Specify: _____

**Medication #2**: _____

Dose of Medication: _____ Route: _____

Time/Frequency of Medication: _____ If PRN, frequency: _____

Relevant Side Effects: _____ None Expected: _____ Specify: _____

**Prescriber's Name/Title:** _____ Telephone: _____
(Print)

Fax: _____

**Prescriber's Signature**: _____

A verbal order was taken by the RN (Name): _____ for the above mediation on (Date): _____

**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 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 Signature: _____ Date: _____

Phone #: _____ Work Phone#: _____ email: _____

**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 the State of Michigan's medication policy.

**Prescriber's** authorization for self carry/self administration of emergency medication:

_____ _____ _____ _____
**(Physician's Signature)** (Date) **(Parent's Signature)** (Date)

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

Order reviewed be the RN: _____ _____
(Signature) (Date)