WENTZVILLE SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

This form is valid only for current school year _____ including the summer session.

School: _____ **Fax Number:** _____

This form must be on file at school prior to school staff administering medication to your child's. A new form, signed my your child's physician, is required 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 properly labeled by pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to school.
- The school nurse will call the prescriber, as allowed by HIPPA, if a question arises about the child and/or medication.

PRESCRIBER'S AUTHORIZATION

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

Condition for which medication is being administered: _____

Medication Allergy: _____

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: _____

(MD, NP, Or PA signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the healthcare provider as allowed by HIPPA.

Parent/Guardian Signature: _____ Date: _____

FOR MIDDLE & HIGH SCHOOL STUDENTS ONLY

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

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

Prescriber's authorization for self-carry/self-administration of emergency medicine: _____

Signature Date

Parent/Guardian authorization for self-carry/self-administration of emergency medicine: _____

Signature Date

School nurse approval for self-carry/self-administration of emergency medicine: _____

Signature Date

☐ Order reviewed and received by School Nurse: _____

Signature of School Nurse Date