SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

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.
*An adult must bring the medication to the school.
*The school CSN/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

Name of Student: _____ DOB: _____ 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)

A verbal order was taken by the CSN/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: _____

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 the State medication policy.

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

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

Order reviewed by the CSN/RN: _____
Signature Date

Cumberland Valley School District Policy for Medication In School

Recognizing there are occasions when it is necessary for the school to administer medication to students during school hours, the following policy has been adopted:

1. In conformance with regulations established by the Pennsylvania Department of Health, no prescribed medication will be administered at the Cumberland Valley School District schools except by written order of a physician. Written authorization from the parent/guardian requesting and permitting the giving of the medication is to be presented to the school nurse. This authorization is to be renewed each school year or each time there is a change in instructions and/or prescription.

2. Medication brought to school must be in the original container dispensed by a pharmacy or doctor. The container label should state the patient's name, date, name of medication, dosage, and time to be given and laced in the custody of the school nurse, principal, or principal's designee for security purposes.

3. All medication shall be administered by the school nurse, principal, or principal's designee (exception Asthma Inhaler Policy).

4. A written record is to be kept on each student receiving medication. The time each dose is given is to be recorded and initialed. Any side effects shall be recorded.

5. The student is to take the medicine in the presence of the person administering the medication.

6. The parents of any student requiring long-term medication should have a conference with the school nurse at the beginning of each school year and when there is a change of medication.

7. All preparations not regulated by the FDA such as herbal, alternatives, teas, nutritional supplements and topical must be accompanied by a physician's written order including exact dosage and timing of administration.

8. Over the counter medication in original container sent in by parent/guardian will be administered for three (3) days, for longer periods of time a doctor's note is required. Professional judgment will prevail when administering ANY medicine at school.

Suggestions:

1. Please ask your pharmacist to make a second labeled prescription bottle for medicine to be taken at school.

2. Medication that is to be given three times a day may be given before school, right after school and at bedtime. (Unless a physician specifies a definite time schedule).

The form on the reverse side of the policy must be completed by the physician or dentist ordering the medicine and by the parent/guardian.

An Emergency Plan should accompany Asthma Inhaler or EpiPen orders from Physician.