

Order reviewed by RN:

Date: \_\_\_\_\_



## Medication Authorization

**TO BE COMPLETED AND SIGNED BY BOTH DOCTOR & PARENT/GUARDIAN**

*Return to Tome School*

### CONSENT FOR ADMINISTRATION OF APPROVED DISCRETIONARY MEDICATIONS AND PHYSICIAN'S PRESCRIPTION MEDICATION ORDER FORM

Part  
A

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 (as needed), for what symptoms: \_\_\_\_\_

\_\_\_\_ Asthma treatment plan attached

Relevant side effects: \_\_\_\_ None expected \_\_\_\_ Specify: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Part  
B

I have checked those medications I wish to be available (as deemed necessary by the Registered Nurse or authorized office personnel) for the school year \_\_\_\_\_. I understand that generic equivalent medications may be used. Medications will be given per PDR (physician's desk reference) and label recommendations and child's weight. (*please note: we do have a scale at school*)

\_\_\_\_ For pain/discomfort – **Acetaminophen** (e.g., Tylenol) – (15mg/kg or \_\_\_\_ mg Q4h PRN)

\_\_\_\_ For bites or allergic rashes – **Anti-itching Lotion** (e.g., Calamine)

\_\_\_\_ For sore throat – **Throat Lozenges** – (1) lozenge (Q2-4h PRN)

\_\_\_\_ For pain/discomfort – **Ibuprofen** (e.g., Advil) – (10mg/kg or \_\_\_\_ mg Q6h PRN)

\_\_\_\_ For upset stomach – **Chewable Antacid** (e.g., Tums)

\_\_\_\_ For mild allergic reactions – **Diphenhydramine** (e.g., Benadryl)

\_\_\_\_ For coughs – **Cough drops** – (1) drop Q4h PRN

Part  
C

Prescriber's Name/Title: \_\_\_\_\_

(Type or print)

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

MUST BE  
SIGNED  
BY M.D.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): \_\_\_\_\_ for the above medication on (Date): \_\_\_\_\_

Part  
D

#### 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. (**MIDDLE & UPPER SCHOOL STUDENTS ONLY**).

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

Part  
E

#### 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: \_\_\_\_\_

# Instructions For Completing Medication Authorization Form (*form on reverse side*)

Part

A

## PART A

Please fill in the students' Name, Date of Birth, and Grade. This section is for medications that your child must take routinely during the school day. This includes Antibiotics, which may be given daily for a short period of time.

Part

B

## PART B

This section is for "Over-the-Counter" medications, which your child may require, to alleviate symptoms of illness, during allergy and cold seasons. You will be notified if your child requires being medicated.

Part

C

## PART C

**This section is only for the prescribing Physician or Nurse Practitioner.** ALL medication, both prescription as well as "over-the-counter", require a Physician's signature. **No medication will be given, unless this form is signed by the Physician, or Nurse Practitioner.**

Part

D

## PART D

This section is for **Middle & Upper School** students who require Emergency medication, such as Albuteral inhalers & Eip-pens, to be carried **BY THE STUDENT**, at all times. If your child requires the use of either of these medications, they are report to the Health Suite immediately. If an Epi-Pen is used, 911 will be called . . . then the parent, and your child will be taken to the nearest Hospital for observation. **Your child's Physician must sign this section, for permission to self-carry emergency medication. No Lower School student may carry emergency medications.**

Part

E

## PART E

This section is for the parent/guardian signature. **No medication will be given without the written permission from the parent/guardian.**

**Addendum** – We will only fax orders to your child's Physician if your child is started on an Antibiotic, and the medication must be given during school. An Authorization Form must be filled out, and signed by the parent, when the medication is dropped off in the office. If your child requires medication, and an Authorization Form is not on file, it will be the parent's responsibility, to come to the school to medicate the child.

**Please remember**, both the Physician, and the parent must sign this form *before* any medication is given to your child.