

MEDICATION ADMINISTRATION AUTHORIZATION FORM 2020-21

This form must be completed fully for the school nurse 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.

PART A: To be completed by medical provider:

Student's Name _____ Date of Birth _____

To keep this student in optimum health and to help maintain maximum school performance, it is necessary that medication be given.

Diagnosis _____
Medication _____ Dosage _____ Route _____
Time(s) given: _____
Special instructions/side effects?

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Medication _____ Dosage _____ Route _____
Time(s) given: _____
Special instructions and/or side effects?

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Medication _____ Dosage _____ Route _____
Time(s) given: _____
Special instructions and/or side effects?

(for inhaler or epipen only) Student may _____ may not _____ self-administer

If medication is ordered as needed, please indicate specific circumstances when medication should be given (licensed nursing personnel will be administering medications.)

Signature of Medical Provider

() _____

Telephone

_____ Date

PART B: To be completed by parent or guardian.

I hereby give permission for my child _____ to receive medication during enrollment at Saint James School. This medication has been prescribed by a licensed physician. I hereby release Saint James School and its agents and employees from any and all liability that may result from my child taking the medication.

Signature of Parent or Guardian

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Telephone

_____ Date