Request for Medication to be Given During School Hours

Macon County Schools

Policy Number: 421

This form must be completed fully in order for schools to administer medication. A new medication administration form must be completed for <u>each school year</u> for <u>each medication</u>, and each time there is a <u>change in dosage or time of administration</u> of a medication.

- **Prescription medication MUST be in a container labeled by the pharmacist or physician.**
- **Non-prescription medication MUST be in the original container with the label intact.**
- **An adult MUST bring the medication to the school.**
- **The school nurse (RN) will call the physician, as allowed by HIPPA, if a question arises about the child &/or the child's medication.**

Physician's Authorization

Name of Student: _____ DOB: _____ Grade: _____

1
Medication Name: _____ Dose: _____ Route: _____ Time/Frequency of administration: _____
If PRN, frequency: _____ Side Effects/Contraindications: ___ None, or specify: _____
If PRN, for what symptoms is medication indicated: _____ Condition for which medication is prescribed: _____

2
Medication Name: _____ Dose: _____ Route: _____ Time/Frequency of administration: _____
If PRN, frequency: _____ Side Effects/Contraindications: ___ None, or specify: _____
If PRN, for what symptoms is medication indicated: _____ Condition for which medication is prescribed: _____

3
Medication Name: _____ Dose: _____ Route: _____ Time/Frequency of administration: _____
If PRN, frequency: _____ Side Effects/Contraindications: ___ None, or specify: _____
If PRN, for what symptoms is medication indicated: _____ Condition for which medication is prescribed: _____

This order is valid Beginning: (Date) _____ Ending: (Date) _____

School: _____

<u>Physician's Contact Information or Stamp:</u>

Physician's Name/Title: _____

Telephone: _____ Fax: _____

Address: _____

_____

(Use for Physician's Address Stamp)

Physician's Signature: _____ Date: _____

A verbal order was taken by School Nurse (RN) for above medication: _____ Date: _____
School Nurse Signature

Parental/Guardian Authorization

I request that the school nurse, or designated school personnel, administer the medication as prescribed by the above physician. I certify that I have legal authority to consent to medical treatment for the student named above, including administration of medication at school. I hereby release the Macon County Schools Board of Education, and their agents and employees from all liability that may result from my child taking this medication at school. I understand that an adult must bring the medication to school, and at the end of the year, pick up any remaining medication. Otherwise, remaining medication will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPPA, and with school staff per FERPA guidelines.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell #: _____ Work #: _____

<u>SELF CARRY – SELF ADMINISTRATION OF EMERGENCY MEDICATION: AUTHORIZATION & APPROVAL</u>

Self carry/self administration of **emergency** medication, for example: EpiPen, Inhaler, Diabetes/Seizure Medications, may be authorized by the <u>physician</u>, <u>parent/guardian</u>, and must be <u>approved by the School Nurse</u> according to Medication Policy. **This student has been trained, can demonstrate the ability to administer medication as instructed, and is approved for self carry/administration of the above medication.**

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Approval: _____ Date: _____

Order reviewed by the School Nurse: _____ Date: _____
School Nurse Signature

cc: Principal, Teacher (as indicated)