AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

State Law & Regulations 10-212(a) require a written medication order of an authorized prescriber (Physician, dentist, optometrist, advanced practice registered nurse or physician assistant and, for the nurse or in absence of the nurse, a designated Principal or teacher/assistant to administer medication). Medications must be in the original properly labeled container dispensed by a physician/pharmacist.

Prescriber's Authorization:

Name of student: _____ Date of Birth:___/___/___

Condition for which Rx is being administered:

_____

Name of Rx:_____ Dose: _____ Route:_____

Time of Administration: _____ If PRN, frequency: _____

Relevant Side Effects: _____

Allergies: Yes ☐ No If yes, describe: ☐

_____

Medication shall be administered from: ___/___/___ through ___/___/___

Prescriber's Name/Title: _____

Phone Number: _____ Fax Number: _____

Address: _____

Nurse/Designee's Signature: _____ Date:___/___/___

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse/designee necessary to ensure the safe administration of this medication.

Parent/Guardian Signature: _____ Date:___/___/___

Phone: _____ Work: _____ Cell: _____

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