CATHOLIC DIOCESE OF YOUNGSTOWN
Office of Catholic Schools

School Medication Administration Authorization Form

Student's Name: _____ DOB: _____

Grade: _____ Teacher: _____ School Year: _____

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 medication administration.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original packaging with the label intact and student's name.
- A parent/guardian **must** bring the medication to school. Students **are not** permitted to bring medication to school.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or child's medication.

♦PRESCRIBER'S AUTHORIZATION♦

(this section must be completed by the prescriber)

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: _____

Special Instructions: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

Date: _____

A verbal order was taken by the school nurse, _____ for the above medication on _____
or designated personnel (name) (date)

_____
Signature

♦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 properly discarded. I/We authorize the school nurse to communicate with the health care provider or prescriber as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

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