

# Gerstell Academy Medication Administration Authorization Form

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of School: \_\_\_\_\_ 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 administration of a medication.**

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- 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 prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.
- The first dose of this medication (except for Epi-pen) has been given without problems.

Having read the above conditions, I request Gerstell Academy School Nurse or designated personnel, in her absence, to administer the medication as prescribed by the Physician below. I certify that I have legal authority to consent to medical treatment for the student above, including the administration of medication at school.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Phone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

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

## **Prescriber's Authorization (ONE MEDICATION PER FORM)**

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: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_

Month / Day / Year

Month / Day / Year

## **For Inhaler, Epi-pen, and Insulin only:**

It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use, including knowing when the medication is to be used.

It has been determined that this student is able to self-administer insulin.

This student should not self-administer inhalant medication, insulin, or Epi-pen.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber's Name (Printed): \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_

## **For completion by the School Nurse:**

Order Reviewed: \_\_\_\_\_ R.N. Date: \_\_\_\_\_