ZEELAND CHRISTIAN SCHOOL

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# MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid for the school year (current) _____, including the summer session.

**This form must be completed fully in order for staff at Zeeland Christian School to administer the required medication. A new Medication Administration Authorization Form must be completed for each medication any time there is a change in the order (i.e., time, dosage,etc.).**

- Prescription medication must be in a container labeled by the pharmacist or provider containing the student and medication names, medication dose and route, frequency of administration, the ordering healthcare provider's name, and a current date (unexpired). All information on the medication must match the information provided on this form.
- Non-prescription medications must be in the original container and unexpired, with the label intact, and labeled with the student's name and date of birth.

Student Name: _____ Date of Birth: _____Grade: _____

## To be Completed by the Physician or Other Authorized Prescriber

Reason for medication: _____

Medication Name: _____Dose:_____

Route: ○ Tablet/Capsule ○ Liquid ○ Inhaler ○ Injection (Subcutaneous) ○ Other_____

Frequency/Time *During* School: _____ If p.r.n., list symptoms/conditions under which medication is to be given: _____

Special Instructions: _____

Restrictions/ possible side effects or adverse reactions: ○ None anticipated ○ Please describe_____

_____

**Additional Information ○ Attached ○ On Back of Form

The student is both capable and responsible to self-carry and self-administer this medication: ○ Yes ○ No

Prescriber's Name/Title (Printed): _____

Address: _____

Phone: _____ Fax: _____

Prescriber's Signature:_____

Date: _____

(Prescriber Address Stamp)

## Parent/Guardian Authorization

I/We request that _____ receive the above medication as prescribed by the above prescriber when necessary for school attendance. I/we request that the student receive the medication above as administered by dedicated school personnel or be permitted to self-carry and self-administer the medication as authorized by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the above named student, including the administration of medication at school. I/We authorize the exchange of information and communication between the health care provider and the school. I agree to inform the school of any changes in medication and/or medical conditions. I realize I may withdraw my request/consent in writing at any time.
If my student will self-administer/self-carry this medication, I agree that in order for them to do so, I will:

- Instruct my student to never share their medication with another person.
- Have my student carry their medication in its original, properly labeled prescriptive/over-the-counter container, along with a copy of this form.
- Have my student carry, other than inhalers, only that day's supply of medication.

Parent/Guardian Signature: _____ Date: _____

School RN approval for self-carry/self-administration of medication:_____Date:_____