Medication Action Plan

School Administration Authorization Form

This order is valid only for school year (current) _____.

This form must be completed fully in order for our school 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 school.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

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

For inhalers or insulin: is the child sufficiently responsible to permit unsupervised self-administration of medication?
☐ yes ☐ no

May the child omit this medication during a field trip? ☐ yes ☐ no

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ Fax: _____

Address: _____

_____

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

Use for Prescriber's Address Stamp

Date: _____ Verbal order taken by: _____

Authorization by Parent/Guardian for the administration of the above medication by school personnel:

I request that the above medication, ordered by his/her medical provider for my child, _____
be administered by school personnel. I give permission for exchange of verbal and written communication between the physician and the school regarding my child's medication regime. I request that my child be assisted in taking the medicine described above at school by authorized persons; or be permitted to medicate herself/himself as also authorized by me and my physician. I understand that I must supply the school with prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 30 school day supply. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or a week beyond the close of school.
I understand that school officials may not be held liable for reactions for medication administered per these directions and at the request of the appropriate guardian.

Printed Name: _____ Signature: _____

Relationship to child: _____ Date: _____

I have reviewed the order for safe implementation. _____ _____
School Nurse Signature Date