CLOVIS MUNICIPAL SCHOOL **GEN 588**

MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _____________ including summer session.

School: ____ Grade: __________________________

This form must be completed fully in order for schools to administer required medication. A new medication administration form must be completed for each year, for each medication, and each time there is a change in dosage or time of medication administration.

- Prescription medication must be in an original 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 will share information relevant to the prescribed medication as he/she determines appropriate for your child's health and safety.

Prescriber Authorization

Name of Student: ____________________________________ Date of Birth: ______________________

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

Prescriber Name/Title: ____________________________ Telephone: ____________________________

Fax: ______________________ Address: ____

Prescriber Signature: ____ Date: _____________________

PARENT/GUARDIAN AUTHORIZATION

I/We, the parent/guardian of ___________________________________ (Student Name) hereby request that this medication be given to my/our child according to the prescriber instructions.

I/We agree to furnish the necessary medication in a pharmacy/original labeled container, to provide replacement medication as necessary, and to provide a new physician's statement if there is ANY change in the medication, dosage, administration time, administration route, or special instructions regarding the medication. I/We understand that other designated personnel (other than the school nurse) may supervise the child with self-administration of medication.

Parent/Guardian Signature____________________________________ Date: ________________________

Home Phone: ___________________ Cell Phone: _______________ Work Phone: _________________

REV. 8/2006