Mount Pleasant Cottage School
Union Free School District

7513F

MEDICATION ADMINISTRATION AUTHORIZATION

Student Name: _____ DOB: _____

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

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.

PRESCRIBER'S AUTHORIZATION

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
I authorize Self-directed medication administration, in the absence of the school nurse by a trained designated staff.
Prescriber's Name/Title: _____ (Type or print)
Telephone: _____FAX: _____E-mail_____
Prescriber's Signature: _____Date:_____

A verbal order was taken by the school RN: _____for the above medication on_____

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. *I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA. *I/We authorize self-directed medication administration, in the absence of the school nurse.

If your child does not receive medication in school please check here____and sign your name in the space provided.

Parent/Guardian Signature: _____ Date: _____

SCHOOL NURSE AUTHORAZATION

❑ I assess this student to be **self-directed*** regarding this medication.

*In the absent of the School Nurse, an individual designated by the Principal, who is trained and supervised by the School Nurse, will conduct the supervision of medication administration. The term "self-direct" is used when your child has been instructed by the School Nurse to know and understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it appropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

❑ Order reviewed by school nurse.

School Nurse Signature _____ Date_____