CLARK SCHOOLS

Name of Student: _____ Date of Birth_____ Grade_____

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

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 medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Over the counter medication, when prescribed, must be in the original sealed container with the label intact.
- An adult must bring the medication to the school.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____ Symptoms _____

Relevant side effects if any: _____

Medication shall be administered from: _____to _____ (Month/Day/Year)

Medication necessary on 1/2 days? Yes No. Necessary for Class or Field Trips? Yes No

Prescriber's Name/Title: _____

Telephone: _____Fax: _____

Address:_____

Prescriber's Signature: _____Date:_____

PARENT/GUARDIAN AUTHORIZATION

I/We request the school nurse to administer the medication as prescribed. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I have discussed with my child's practitioner field trips and early dismissal days. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPPAA.

Parent/Guardian Signature:_____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____