JKL Bahweting Public School Academy

JKL Fax # 906-635-3805 Attn: School Nurse

MEDICATION ADMINISTRATION AUTHORIZATION FORM

(This order is valid only for school year **2023-2024** including the summer session)

* This form is required, by law, for all medications, including ***non-prescription (over-the-counter)*** medication.
* No medication will be administered without both the prescriber's and the parent/guardian's signatures.
* A separate authorization form is required for each medication.
* A new authorization form must be completed any time there is a change in a medication's strength or time of administration, and at the beginning of each school year.

PRESCRIBER'S AUTHORIZATION AND ORDER

This section is to be filled out by the student's doctor (or PA/NP)

Name of Student: _____ Date of Birth: _____Grade:_____

Medication Name & Strength: _____ Dose: _____ Route: _____

Frequency or time(s) to be administered: ❑ start of school ❑ before lunch ❑ after lunch ❑other: _____

❑Prn frequency_____PRN

Diagnosis or reason for medication: _____

Significant potential side effects: ❑ none expected ❑ specify: _____

Medication shall be administered from: _____ to:_____

(Month/Day/ Year-no earlier than 9/1/2023) (Month/Day/Year -no later than 08/31/2024)

If this medication is an asthma inhaler, epinephrine auto-injector, or other emergency medication, is student authorized to self-carry/self-administer? ____ yes ____ no

Prescriber's Name/Title: _____ Phone: _____ Fax: _____

Prescriber's Signature: _____ **Date**: _____

PARENT/GUARDIAN REQUEST & AUTHORIZATION:

I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I authorize the school nurse to communicate with the above health care provider as allowed by HIPAA.

□ Check this box if you are requesting and approve to have your child self-carry/self-administer his or her medication as authorized by the above prescriber.

Parent/Guardian Signature: _____ **Date:** _____

Home/Cell Phone #: _____ Work #: _____ Email: _____

SCHOOL RN APPROVAL FOR SELF-CARRY AND/OR SELF-ADMINISTRATION OF MEDICATION

Self-carry and/or self-administration of medication (including emergency medication) that is authorized by the prescriber above must be approved by the school nurse according to the Academy's medication policy.

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

Signature Date

*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.

*The school nurse (RN) will call the prescriber if a question arises about the child and/or the child's medication. 6/1/2023