SCIOTO VALLEY LOCAL SCHOOLS

Medication Authorization Form

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

STUDENT NAME: _____ **BIRTHDATE:** _____ **SCHOOL/YEAR** _____

MEDICAL PROVIDER INSTRUCTIONS: This portion may only be completed by the medical provider- i.e MD/DO/NP/DDS

Medicine Name	Dosage	Route	Time/Frequency
		__ ORAL __ EYE DROP __ TOPICAL __ EAR DROP __ OTHER _____	

Purpose of Medication: _____

If PRN, for what symptoms: _____

Further Instructions (possible reactions, etc.): _____

Starting Date: _____ **Ending Date**: _____

___ (Physician initials) Self-Carry: (Jr High/High School Only)

I request that the above named student be allowed to have personal possession of the above medication and be permitted to self-administer this medication within the school district policy and prescription instructions.

****I understand that a backup rescue asthma inhaler, epi pen, or emergency medications for seizures and diabetes needs to be kept in the nurses clinic in case of an emergency or child needs medication and forgot their self-carry dose.**

****I also agree that the above named child understands proper use of the above medication and can properly demonstrate use. Child also understands that medication is not to be shared with any other child.**

Medical Provider Signature: _____ **Date:** _____

_____ _____ _____

Provider Name (Please Print) **Phone** **Fax**

Please Fax order to School District Nurse: Mandy Day BSN, RN, SNL Phone 289-2425 Fax 289-2889

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THIS PORTION MUST BE COMPLETED BY THE PARENT OR LEGAL GUARDIAN

I hereby give my permission for my child (named above) to receive the above medication at school. I assume full responsibility and will inform school staff of any changes for medication or health status. I hereby release Scioto Valley Local School Board, their agents, and employees from any and all liability that may result from this medication administration. I agree to furnish medication in original, properly labeled pharmacy or store container. I understand that at the end of the school year, an adult must pick up the medication on or before the date given to parents, otherwise it will be discarded. I authorize the school nurse to communicate with the health care providers as allowed by HIPAA.

PARENT SIGNATURE: _____ **Date:** _____

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Order reviewed by the school RN: _____ **Date:** _____