Oaklyn Public Schools
SCHOOL MEDICATION ADMINISTRATION 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.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.
* Efforts will be made to employ a substitute nurse to accompany the class when students with health/medication needs on field trips; however, the district cannot guarantee the availability of a substitute nurse.
* **A parent or guardian may accompany the student on a field trip for the purpose of administering medication.**

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

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: _____

This medication may be omitted on half-days and field trips: _____ **YES** _____ **NO**

This order is valid only for school year (current) _____to_____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title:_____
(Type or print)
Telephone: _____FAX: _____

Address:_____

_____

Prescriber's Signature: _____Date:_____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

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 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/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

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