

KRIEGER SCHECHTER DAY SCHOOL

PHYSICIAN'S MEDICATION AUTHORIZATION FORM

A Physician's Medication Authorization Form must be completed at the beginning of each school year for all medications.

- This form must be completed and signed by the parent and the child's medical provider in order for us to administer ANY required medication. This includes both prescription and over-the-counter (OTC) medications.
• All prescription medication must be in a container with the pharmacist's label attached.
• Non-prescription medication must be in the original container with the manufacturer's original label intact.
• The medication is required to be brought to school by a parent/guardian or responsible adult.
• It is recommended that the first full day's (24 hours) dose of any new medication be given at home.

HEALTH CARE PROVIDER'S INSTRUCTIONS FOR GIVING MEDICATION

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: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____

Prescriber's Signature: _____ Date: _____

Telephone: _____ FAX: _____

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 #: _____

AUTHORIZATION FOR STUDENT TO CARRY EPI-PEN AND/OR INHALER

Self carry/self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization (Signature and Date): _____

Parent/Guardian (Signature and Date): _____

To Be Completed by School Nurse: Medication expires: _____

Contact School Nurse at (410) 486-8640 X247. Forms may be faxed to (410) 486-6106, Attn: School Nurse.