In the pursuit of excellence…

Caledonia Community Schools

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) **2024/2025**

School: _____

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. Medication must be age appropriate as stated on the bottle.
* An adult must bring the medication to the school. Medication must not be expired.
* 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.
* If your child is Medicaid eligible, school health services may be billed on behalf of the school. School district billing will not impact future benefits of your family's Medicaid Plan.

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

Allergies _____ Condition for which medication is being administered: _____

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

Time/frequency of administration: _____ If Taken as needed, for what symptoms: _____

_____

Relevant side effects: □ None expected □ Specify: _____

PRESCRIBER'S AUTHORIZATION

(For prescription medication only)

Prescriber's Name/Title: _____

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 Printed Name: _____ Date: _____

Parent/Guardian Signature: _____ Home/Cell Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of medication (only emergency medication) may be authorized by the prescriber and must be approved by the school nurse according to the School Nurse Program medication policy.

Prescriber's authorization for self carry/self administration of medication: _____ _____

Signature Date

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

Signature Date

Order reviewed by the school RN: _____ _____

Signature Date