SLIDELL INDEPENDENT SCHOOL DISTRICT

Medication Administration Authorization

Student Information

Student Name:	DOB:	Grade:
Campus:	Parent/Guardian Name:	Parent Phone:

Prescription Medication Information

Medication Name: _____

Dose: _____ Route: _____

Time(s) to be Administered at School: _____

Frequency:_____

Diagnosis/Reason for Medication: _____

Special Instructions for School Staff:

_____

Precautionary, if any: _____

Prescription Number: _____

Parent/Guardian Authorization

☐ I request that Slidell ISD personnel administer the prescription medication listed above.

☐ Medication is in the original pharmacy-labeled container with current instructions.

☐ I understand unused medication must be picked up by the parent/guardian. Medication not picked up after reasonable notification may be disposed of according to district procedures.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Healthcare Provider Order

Healthcare Provider: _____Office Phone: _____ Fax: _____

Provider Signature: _____ Date: _____

Provider Instructions/PRN Parameters: _____

School Nurse Use Only

Date Received: _____ Pharmacy Label Verified: ☐ Yes ☐ No Expiration Date: _____ Quantity Received: _____ Nurse Initials: _____