SCHOOL MEDICATION ADMINISTRATION FORM

OWOSSO PUBLIC SCHOOLS
Ready for the World

Student Name: _____

Date of Birth: _____

The order is valid for school year: _____

School & Grade Level: _____

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.
- A parent or guardian must bring the medication to the school.

	Medication Name:	Dose:	Time to be Given:	Form/Route*:	Side Effects:	Adverse Reactions:
1.						
2.						

*Route: oral (pill/capsule/chewable/liquid), inhaled (inhaler, nebulizer), topical skin application, eye or ear drop/ointment, other

Medication #1 _____ Medication #2 _____
Reason for Medication(s): _____
Start/Stop date if not the beginning of the school year: _____

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: _____ Cell Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

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

Physician Signature: _____Date: _____

Physician Printed Name: _____ Physician Phone: _____

Parent/Guardian Signature: _____Date: _____

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

School Nurse Signature: _____ Date: _____