MILLERSVILLE CHRISTIAN ACADEMY

School Medication Administration Authorization Form

This form must be completed fully in order for school 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/guardian must bring the medication to school and check it in with office staff.
- The school nurse (RN) will call the prescriber, as followed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization
(To be completed by the health care provider)

Student Name: _____ DOB: _____ 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

Self-Carry/Self-Administration of Emergency Medication Authorization/Approval

Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions. Self-administration of medication must be approved by the school nurse according to policy. **See back of form for student self-carry contract. Only medications that a student may self-carry or self-administer are emergency medications such as asthma inhalers, epinephrine, insulin, or glucose.**
Student is competent to carry and administer own medication. ☐ Yes ☐ No (Prescriber to authorize)

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 and the ability to self-carry if deemed appropriate by the prescribing provider. 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 release the school, board, and their agents and employees from all liability that may result from my child taking the prescribed medication. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____Cell Phone #: _____ Work Phone #: _____

Order reviewed by the school nurse (RN) : _____ Date: _____

MILLERSVILLE
CHRISTIAN ACADEMY

Contract for Self-Carried Medication

Student: _____ School: _____ Grade: _____

Physician: _____ Telephone: _____

Medication: _____

Medication is permitted in accordance with state laws and district policy. Both student's healthcare provider and parent/guardian must complete Medication Authorization Form. Student's name must appear on the medications and devices.

Responsibilities of Student

- I plan to keep my inhaler/equipment, Epinephrine auto-injector, or diabetes medication/equipment with me at school.
- I agree to use my inhaler/equipment, Epinephrine auto-injector, or diabetes medication/equipment in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my medication or equipment.

Student's signature: _____

_____ Emergency Action Plan complete and on file at school.

_____ Parent did not request Emergency Action Plan for condition which medication is being administered.

_____ Demonstrated correct use/administration.

_____ Verbalizes proper and prescribed timing for medication.

_____ Agrees to carry medication in an agreed location _____

_____ Can describe own health condition well.

_____ Keeps a second labeled container in office.

_____ Student verbalizes he/she will not share medication or equipment with others.

Comments: _____

School Nurse Signature: _____ Date: _____