Lincoln County School District #2
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current)_____including the summer session.

School: _____

This form must be completed fully in order for LCSD2 to administer the required medication. An adult must bring medication to school. 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/product must be in the original container with the label intact and student's name written on container.
* 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.

Required Prescription and Non – Prescription Medication Information

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

Required Prescriber's Authorization for Prescription Medication

Prescriber's Name/Title:_____
(Type or print)
Telephone:_____FAX: _____

Address:_____

_____

Prescriber's Signature:_____Date:_____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name):_____for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION: Check Appropriate BOX

☐I/We request designated school personnel to administer the medication as prescribed by the above prescriber.
☐I/We request designated school personnel to administer the non – prescription medication/product as described above.
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 #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

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 for self carry/self administration of emergency medication: _____
Signature Date

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

Order reviewed by the school RN: _____
Signature Date