Bishop Fenwick High School

School Medication Administration Authorization Form- **Prescribed by MD**

This order is valid only for school year (current) _____

This form must be completed fully in order for the school nurse 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 the medication.

- Prescription medication must be in a container labeled by the pharmacist.
- An adult must bring the medication to the nurse's office.
- NO more than 30 day supply may be kept in the nurse's office.

Prescriber's Authorization

Name of Student:_____DOB_____Grade_____
Medication Allergies:_____
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

Prescriber's Name/Title:_____
(Type or print)
Telephone: _____Fax:_____
Address:_____
Prescriber's Signature: _____Date:_____

Parent/Guardian Authorization

I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/GuardianSignature:_____Date:_____
Home Phone: _____Cell Phone:_____ Work Phone:_____

Self Carry/Self Administration of Medication

Self carry/self administration of medication may be authorized by the prescriber and must be approved by the school nurse.

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

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

Revised BFHS/JMF 06/2019