LAKESHORE PUBLIC SCHOOLS

**SCHOOL PRESCRIBED MEDICATION ADMINISTRATION AUTHORIZATION FORM**

**This order is valid only for school year (current) _____ including the summer session.**

**School Building:** _____

**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.
* An adult must bring the medication to the school.
* The school will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication;

## Prescriber's Authorization

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 will be given from: _____ to _____ Given between: _____ am/pm & _____ am/pm
Month I Day I Year Month I Day I Year *** SEE BELOW**

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)

## 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 to communicate with the health care provider as allowed by HIPAA. ***Parent agrees to contact the school if medication is needed outside of regularly scheduled hours (extended field trips or school activities that are not within a normal school day).**

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

## *SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL*

**Lakeshore Public Schools will only allow an inhaler or EpiPen to be self administered by students. All other medications must be administered in the school office.**

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

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

LAKESHORE PUBLIC SCHOOLS

**OVER THE COUNTER MEDICATION ADMINISTRATION AUTHORIZATION FORM**

**This order is valid only for school year (current) _____ including the summer session.**

**School Building:** _____

**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.**

* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.

## Parent's Authorization

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 will be given from: _____ to _____ Given between: _____ am/pm & _____ am/pm
Month I Day I Year Month I Day I Year *** SEE BELOW**

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## PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as identified 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. ***Parent agrees to contact the school if medication is needed outside of regularly scheduled hours (extended field trips or school activities that are not within a normal school day).**

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

## NOTES