Canton City School District
Health Services
Medication Authorization

Student Name________________________________ DOB______________

School________________ Grade______ Teacher______________________

Medication Allergies/ Interactions______________________________

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 medication administration.

- ➔ Prescription medication must be in a container labeled by the pharmacist or prescriber.
- ➔ Non-prescription medication must be in the original packaging with the label intact and contain the student's name.
- ➔ A parent/guardian must bring the medication to school. Students are not permitted to bring medication to school.
- ➔ The school nurse will call the prescriber, as allowed by HIPAA / FERPA, if a question arises about the child and/or child's medication.

PARENT / GUARDIAN AUTHORIZATION

I/We authorize designated school personnel to administer the medication as prescribed by the prescriber (below). 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 the ***medication must be in the original container*** and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate. I/We understand that at the end of the school year, an adult must pick up the medication; otherwise it will be properly discarded. I/We authorize the school nurse to communicate with the health care provider/prescriber or pharmacist to clarify the below listed medication order as allowed by HIPAA / FERPA.

Parent/Guardian Signature______________________________ Date __________

Contact Phone #1____________________ Contact Phone #2 ____________________

PRESCRIBING PROVIDER'S AUTHORIZATION

(this section MUST be completed by the prescribing provider)

Condition for which medication is being administered______________________________

Medication____________________ Dose______________ Route______________

Time______________ Date of medication to begin__________ Date of medication to end__________

(please note: orders are only valid for one school year)

If PRN, frequency____________ If PRN, for what symptoms ______________________

Relevant side effects: None expected Specify______________________________

Prescriber Name/ Title______________________________

Phone________________ Fax ________________

Prescriber's Signature______________________________

Date____________ ***(blank area above for provider's stamp)***

☐ RN (school) has reviewed this completed parent form and prescriber's orders, Sign____________________Date __________