PINELAND LEARNING CENTER
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

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 a medication. Completed form maybe fax to 856-378-5025.

- **Prescription medication must be ordered by a physician or dentist and in the original container with the original label intact.**
- **Non-prescription medication must be in the original container with the label intact.**
- **An adult must bring the medication to the school.**
- **The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about your child's medication.**

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Student Name: _____ DOB: _____ Grade: _____

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of administration: _____ If PRN, frequency: _____

Condition for medication is being administered: _____

Relevant side effects: None expected: ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Physician's Name/Title: _____

Telephone: _____

Address: _____

Physician's Signature: _____ Date: _____

(USE FOR PHYSICIAN'S ADDRESS STAMP)

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of emergency medication may be authorized by the physician and must be approved by the school nurse according to the State medication policy.

Physician's authorization for self-carry/self-administration of emergency medication: _____
Signature/Date

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

TO BE COMPLETED BY PARENT/GUARDIAN

I/We request designated school personnel to administer the medication as prescribed by the above physician. 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 properly discarded. I/We authorize the school nurse to communicate with the physician as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Signature of school nurse who reviewed order: _____ Date: _____