Pineland Learning Center

Educating. Empowering. Transforming.

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SCHOOL MEDCIATION ADMINISTRATION AUTHORIZATION FORM

This order is valid for the current school year __________, including the Extended School Year (ESY) program.

This form must be completed in full by a Licensed Healthcare Provider (MD, DO, DMD, APN) for the school nurse to administer your child's medication during school hours. Each medication administered during school hours requires a separate form. A new School Medication Administration Authorization form must be provided at the beginning of each school year; and whenever there are any changes in dosage or time medication is to be administrated.

- **Prescription medication must be ordered by a Healthcare Provider and be in the original container with the original label intact.**
- **Non-prescription medication must be ordered by a Healthcare Provider and be in the original container.**
- **To transport medication to school, please contact school nurse.**

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER

Student Name: ____ DOB: ________________ Grade: __________

Medication Name: ____ Dose: ________________ Route: __________

Time/Frequency of administration: ________________________________ If PRN, frequency: __________________________

Condition medication is being administered: ____

Relevant side effects: None expected: ______ Specify: ____

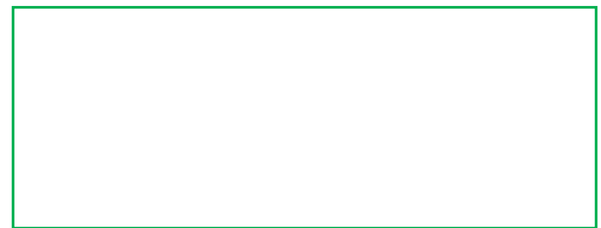
Medication shall be administered from: ____________________________ to ____________________________
Month/Day/Year Month/Day/Year

Physician's Name/Title: __________________________________

Telephone: ____

Address: ____

Physician's Signature: _______________________ Date: _________



(USE FOR PHYSICIAN'S ADDRESS STAMP)

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: ____________________

Revised 8/2024