MEDICATION AUTHORIZATION FORM

(Please complete one form for each of your student's medications.)

Student's Name:_____ **DOB:**_____

Allergies:_____

Reason for medication or diagnosis: _____

Medication: _____

Dosage:_____ **Time of Day to be Administered:**_____ ☐ **AM** ☐ **PM**

School:_____ **School Year:** _____

In order for school personnel to administer any type of medication to the student, the Parent/Guardian must provide this signed authorization form. Medicine will be dispensed to the student by the School Nurse or by unlicensed school personnel trained and deemed competent by the School Nurse. The medicine must be sent to the school with complete instructions and in the original container with the Physician's Order **OR** pharmacy label firmly attached to the medication.

Please be sure to complete ALL of the information on this authorization form before returning it to school.

ANY OVER THE COUNTER MEDICATIONS MUST BE ACCOMPANIED BY A PHYSICIAN'S ORDER

Medication to be administered during the school day must be brought to the school by the Parent/Guardian. Parents/Guardians shall pick up unused medication within two (2) weeks of the last day of school or it shall be destroyed. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

The first dose of any new medication should NOT be given at school.

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PARENT/GUARDIAN STATEMENT

☐ *I, the undersigned Parent/Guardian of the student named above, request that a* ****trained staff member administer*** *the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or the medication will be destroyed.*

**** Parent / Student are responsible to have medication available at school.***

X_____ ***/____/ ____***

(Parent/Guardian's Signature) Date

Home Phone:_____ Work:_____ Cell: _____

*Reviewed by:*_____ *RN* *Date:* _____

PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION

(Please complete one form for each medication.)

Student's Name: _____ **DOB:** _____

Allergies: _____

Medication: _____ **Dosage:** _____

Reason for medication or diagnosis: _____

School: _____ **School Year:** _____

In order for students to self-administer medication at school, the Parent/Guardian shall provide this signed authorization form. Also, a Physician's Order (see box below) is required for students to self-administer medication. Please be sure to complete ALL of the information on this authorization form before returning it to school. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

* It is recommended that only middle and high school students are allowed to carry and self-administer their own medication. For elementary age children, arrangements can be made to keep inhalers or emergency medications in the classroom. The student's teacher will provide monitoring for the child's safety.

PHYSICIAN'S ORDER

1. I have examined this student for (diagnosis) _____ and have determined that he/she requires medication during school hours.
2. Name of Medication _____ ..... 3. Dosage & Route: _____
4. I believe this student is able to carry and administer his or her own medication at the appropriate time and in the appropriate way. **Please check: ____ YES ____ NO**

Physician's Signature: _____ **Date:** ____/____/____

Printed Name: _____ **Phone:** _____

PARENT/GUARDIAN STATEMENT

I, the undersigned Parent(s)Guardian(s) of _____ give consent for *****my student to self-administer*** *the above medication(s). I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by the School Nurse or school staff.*

The School Nurse reserves the right to monitor student periodically during the school year.

* ***Parent / Student are responsible to have the medication available at school.***

X _____ ____/____/____

(Parent/Guardian Signature) Date

Home Phone: _____ Work: _____ Cell: _____

Reviewed by: _____ RN Date: _____

PHYSICIAN ORDER FOR MEDICATION

(Please complete one form for each medication.)

Under Kentucky Nursing Law, a licensed nurse must have a Medication Order from a Physician, Dentist, Nurse Practitioner, or Physician's Assistant to administer or delegate to unlicensed school personnel to administer any prescription medication or any over-the-counter (OTC) medication. This form must be completed by the student's medical provider and be on file at the school before any medication can be given. Medicine will be administered to the student by the School Nurse or by unlicensed school personnel trained and delegated to administer medication by the School Nurse.

The medicine must be sent to the school in the original container.

Physician Order - Medication

Student's Name:_____ **DOB:**_____

Allergies: _____

School: _____ **School Year:** _____

Medication Name:_____ **Time to Administer at School:** _____

Dosage: _____ **Frequency:**_____ **Route:**_____

Start Date:_____ **Duration of Order** _____

Possible Side Effects of the Medication _____

Reason for Medication or Diagnosis: _____

X _____ ____/____/____
(Physician's Signature) Date

_____
(Printed Name)

Telephone:_____

FAX**:** _____

*Reviewed by:*_____*RN Date:* _____