Pittsgrove Township Schools

School Medication Administration Authorization Form

Name of Student: _____ **Date of Birth** _____ **Grade/Teacher:** _____

This order is valid only for current school year. 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 medication.

- Parents and legal guardians are encouraged to administer medications to children at home whenever possible as medication should be administered in school only when necessary for the health and safety of pupils
- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Over the counter medication, when prescribed, must be in the original sealed container with the label intact.
- An adult must bring the medication to the school.

Prescriber's Authorization

Condition for which medication is being administered: _____

Medication:_____ Dose:_____Time: _____AM/PM

Daily ❒ Yes ❒ No PRN every _____hours If PRN, for what symptoms: _____

Dates to be dispensed: Entire School year ❒ Yes ❒ No Limited course of treatment: _____

Relevant side effects: ❒ None expected Specify: _____

Medication necessary on ½ days ❒ Yes ❒ No

Necessary for Class or Field Trips (emergency medication only) ❒ Yes ❒ No

Prescriber's Name/Title: _____

Telephone: _____ Fax: _____

Prescriber's Signature: _____ Date:_____

(Original signature or signature stamp ONLY)

(HCP office stanp-required)

Self Carry/Self Administration of Emergency Medication Authorization/Approval

Self carry/self administration of emergency medication such as Asthma inhaler, Epinephrine and Diabetic Medications/Glucagon may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy. Prescriber's authorization for self carry/self administration of emergency medication:

Permission to Self/Carry and self administer at all times ❒ Yes ❒ No May Self Carry for Class or Field Trips ❒ Yes ❒ No

Prescriber's Signature: _____ Date:_____

(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION I/We request the school nurse to administer the medication as prescribed. 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 shall indemnify and hold the district or its employees and agents harmless from any claims arising out of the self administration of the medication**.** I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA/FERPA.

Parent/Guardian Signature: _____ Date: _____