CROOK COUNTY SCHOOL DISTRICT #1

Mark Broderson, Superintendent
Hulett- Moorcroft- Sundance
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REQUEST FOR MEDICATION ADMINISTRATION FORM

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

This form must be completed fully in order for the school 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.

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

PRESCRIBER'S AUTHORIZATION

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____Dose: _____Route: _____

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

If PRN, for what symptoms: _____

Relevant side effects: □ None expected □ Specify: _____

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

Prescriber's Name/Title: _____
(Print)

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY) (Use Above Space for Prescriber's Address Stamp)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. 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 authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone#: _____ Cell Phone#_____ Work Phone#: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication 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: _____
Signature Date

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

Order reviewed by the school RN: _____ Date: _____