Shorashim
ACADEMY

AUTHORIZATION FORM FOR
ADMINISTRATION OF PRESCRIPTION MEDICATION IN SCHOOL

State law requires a physician/dentist/APRN/PA's written order and the parent's and/or guardian's authorization to administer medications or, in his/her absence, the principal and/or designated staff to administer medications. Medications must be in pharmacy-prepared containers and labeled with the name of the student, name of drug, strength, dosage, frequency, name of physician/dentist/APRN/PA, and date of original prescription.

PHYSICIAN/DENTIST/APRN/PA ORDER

Name of Student: _____ Date: _____

Address: _____ DOB: _____

Condition for which drug needs to be administered during school hours:

_____

Drug (name, dose, method of administration):

_____

Medication should be administered at: _____ AM _____ PM

How many days should it be administered: _____

Licensed Prescriber's Signature: _____

AUTHORIZATION BY PARENT/GUARDIAN OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL

To School Personnel:
I request that the above medication, ordered by the physician/dentist/APRN/PA for my child, _____, be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 30 day supply. I understand that the medication will be destroyed if not picked up following one week after termination of the order or one week beyond the close of school.

Parent/Guardian Name: _____

Signature: _____

Phone: _____ Date: _____