EAST JACKSON COMMUNITY SCHOOLS
East Jackson Elementary School

Amy Blackledge
Principal

Jimmie Jones
Dean of Students

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Jackson, MI 49201

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SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for the current school year_____, including the summer session.

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 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 the medication to the school.
*The school nurse (RN) 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: _____
Type or Print

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original Signature or Stamp ONLY)

SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of medication (including **emergency medication**) may be authorized by the prescriber and must be approved by the school nurse according to the East Jackson Community Schools medication policy.

Prescriber's authorization for self carry/self administration of medication: _____
Signature Date

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

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Phone #: _____ Work #: _____

Principal's Signature _____