Student Medication Authorization Form 8

ARCHDIOCESE OF WASHINGTON - Catholic Schools

NOTE: This is a release and indemnification agreement authorizing the administration of medication. It is NOT an authorization for an inhaler or an epi-pen.

Please use a separate form for each medication.

PART I: TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: ______________________ Sex: male ☐ female ☐ Birth Date: ______________

School's Name: ______________________ School Year/Grade ______________

Allergies: ____

Medication: ☐Renewal ☐NEW ***If new, the first dose must be given at home** First dose given: Date/Time __________

PART II: TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER WITH NO ABBREVIATIONS

<<Type school's name here>> discourages the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific situations with appropriate forms that comply with LHCP orders and are signed by the parent or guardian. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and school crisis situations according to the procedures outlined herein.

Diagnosis: ______________________ Medication and Route: ______________________

Dosage to be given at school & interval for repeating: ______________ Time to be given: ______________

Common Side Effects: ____

Effective Date: Start __________ End ______________

If student is taking more than one medication at school, list sequence in which medications are to be take: ______________

____

Licensed Healthcare Provider: ______________________ Phone: ______________

Signature of LHCP: ______________________ Date: ______________

PART III: TO BE COMPLETED BY PRINCIPAL AND REGISTERED NURSE

Check as appropriate:

☐ Parts I, II AND Parent Information are completed including signature. (It is acceptable if Part II is written on the LHCP stationery or prescription pad).

☐ Medication is appropriately labeled. __________ Date by which any unused medication is to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

Signature of Nurse: ______________________ Date: __________

Signature of Principal: ______________________ Date: __________

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