Authorization for Administration of Medication

Hand in Hand Christian Montessori

Child's Name _____ DOB: _____ Classroom: _____ School Year:_____

Physician/Licensed Prescriber Order for Administration of Medication by School Staff

(TO BE COMPLETED BY HEALTH CARE PROVIDER)

Medication Start Date: _____ Medication End Date: _____

(All authorizations expire at the end of the school year or following the summer school session.)

Medication	**Medical Diagnosis** (ICD-10-CM Code)	**Dose**	**Frequency/Time**	**Route**	**Special Instructions**

_____ _____ _____

Physician/Licensed Prescriber Signature | Print Name of Physician/Licensed Prescriber | Date

_____ _____ _____

Clinic Name & Address | Phone # | Fax #

Parent/Guardian Medication Authorization & Permission for Release of Information

(TO BE COMPLETED BY PARENT/GUARDIAN)

1. I request that the above medication be given during school hours as ordered by the student's physician/licensed prescriber. I also request that the medication be given on field trips, as prescribed.
2. I give permission for the medication to be given by designated staff as assigned or delegated, trained, and supervised by the school nurse/health consultant.
3. I will notify the school in writing of any changes that are made to medication and/or regimen (i.e. dosage change or medication stopped).
4. I give permission for the school health staff to communicate, as needed, with school staff about my child's medical condition and the action of the medication.
5. I give permission for the school health staff to consult with my child's physician/licensed prescriber about any questions regarding the listed medication or medical condition(s) being treated by medication.
6. I give permission for the physician/licensed prescriber to release information related to the above medication and medical condition(s) to the school health staff.

_____ _____ _____

Parent/Guardian Signature | Date | Phone #

Please submit this completed form to the school office with the medication in original/prescription bottle.

Return of Unused Medication to Parent/Guardian

(TO BE COMPLETED WITH SCHOOL STAFF)

Quantity (if controlled substance): ___ Staff signature: _____ Parent's initials: _____ Date: _____

Information Regarding the Administration of Medication at School

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1. Parents/guardians asking school staff to give medication must provide written permission every school year that has been signed by the parent/guardian.

2. The student's physician/licensed prescriber much also provide written authorization for all prescription medications and select over-the-counter medications.

3. Prescription medications must come in a container labeled by the pharmacy (*ask the pharmacist to put the medication in two containers if you also need one for home).* The following information must be on the label and match the prescriber's order:
    a) Child's name
    b) Name and dosage of medication
    c) Time/frequency medicine is to be given
    d) Physician/licensed health care provider's name

4. Over the counter medication must be packaged in an original container with the manufacturer's label intact and clearly indicating dosage, instructions, and ingredients. Please also write your child's name on the container.

5. Medications should be brought to school by a parent/guardian or a responsible adult. If there is any medication remaining after treatment, or at the end of the school year, please make arrangements for it to be picked up. School staff will not send medications home with students.

6. Parents must notify the school in writing if a medication is discontinued.

7. A new medication consent form is required:
    a) When the dosage or time of administration is changed
    b) At the beginning of each school year
    c) If a discontinued medication is restarted

8. The school nurse/health consultant will designate appropriate storage for medications. Medications will not be accessible during non-school hours unless arrangements are made ahead of time with the health office.

We look forward to serving your family! Please email our health services staff at healthoffice@hihcm.org *with any questions or special considerations.*