Hinds County School District

SCHOOL MEDICATION ADMINISTRATION/AUTHORIZATION FORM

This order is valid only for school year ___________________________________

This form must be completed fully in order for schools to administer the required medication. A new medication form must be completed at the beginning of each school year, for each medication, and each time there is a change in do or time of administration of a medication.

- Prescription medication must be in a labeled container.
- Non-Prescription medication must be in the original container with a label.
- An adult must bring the medication to school. It cannot be transported on the bus.
- The school nurse will call the prescriber if a question arises about 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 ________________________

Prescriber's Name/Title: ____

Telephone: _______________________ Fax: ____________________

Address: ____

____

Prescriber's Signature: ___________________________ Date: ________

A verbal order was taken by the school RN (Name): __________________________ (Date): ______________

AUTHORIZED MEDICATON ADMINISTRATOR

____ Enrollment card has been reviewed and parent signature is on file giving permission for medication to be given at school according to physician instructions.

____ Medication has been received and is in its labeled container.

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: _______________

School RN approval for self carry/self administration of emergency medication: ____________________

Order reviewed by the school RN: _________________________________ Date: ___________________