MADE HOUSTON

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MADE Houston
School Medication Administration Authorization Form
2021-2022

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.
- A parent/guardian must bring the medication to school and check it in with office staff.
- Administration staff will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.
- Complete a separate form for each medication.

Prescriber's Authorization

(To be completed by the health care provider)

Name of student:_____DOB:_____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

Self-Carry/Self-Administration of Emergency Medication Authorization/Approval

Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions. Self-administration of medication must be approved by the school nurse according to policy. **See back of form for student self-carry contract.**

Only medications that a student may self-carry or self-administer are emergency medications such as asthma inhalers, epinephrine, insulin, or glucose.

Student is competent to carry and administer own medication. ☐ Yes ☐ No (Prescriber to authorize)

Prescriber's Name/Title:_____
(Type or Print)
Telephone:_____FAX:_____
Address:_____

Prescriber's Signature:_____Date:_____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

Parent/Guardian Authorization

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school and the ability to self-carry if deemed appropriate by the prescribing provider. I/we understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We release the school board and their agents and employees from all liability that may result from my child taking the prescribed medication. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian Signature:_____Date:_____

Home Phone #:_____Cell Phone #:_____Work Phone #:_____

Order reviewed by the school administration:_____

Signature Date