# Al-Rahmah School (ARS)

## SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _____ including the summer sessions

**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

Child's Picture (Optional)

### PRESCRIBER'S AUTHORIZATION

Child's Name:_____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name:_____ Dose:_____ Route: _____

Time/frequency of administration:_____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions:_____

Medication shall be administered from:_____ to_____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain_____

Prescriber's Name/Title: _____
(Type or print)

Telephone:_____ FAX: _____

Address: _____

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

This space may be used for the Prescriber's Address Stamp

### PARENT/GUARDIAN AUTHORIZATION

I/We request designated Al-Rahmah 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/child named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be disregarded. I/We authorize authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:_____ Date: _____

Home Phone #:_____ Cell Phone #:_____ Work Phone #: _____

### SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

**(Only school-aged children may be authorized to self carry/self administer medication.)**

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature — Date

Parental approval: _____
Signature — Date

### FACILITY RECEIPT AND REVIEW

Medication was received from:_____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form — Date