ARKANSAS SCHOOL FOR THE DEAF
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _2020-2021_____ including the summer session.

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 medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or 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 _____
Month/Day/Year Month/Day/Year

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 hereby give my permission for my child, named above, to have administered the above medication while attending the Arkansas School for the Deaf. I understand it is my responsibility to provide this medication in the original container labeled by the pharmacy or physician, including the name of my child, the name of the medication, the dosage, and time of administration. **I understand that medications arriving in baggies, envelopes, etc., labeled or not, will not be given.** I further understand that any school employee who administers any drug in accordance with written instructions from a physician or dentist shall not be liable for damages as a result of administering the drug as directed. I am responsible for updating this form if medication or dosages change.

Signature of Parent/Guardian: _____ Date: _____

Order reviewed by school nurse: _____
Signature Date

Rev: 06/16