HOLY HILL AREA SCHOOL DISTRICT MEDICATION ADMINISTRATION AUTHORIZATION FORM

*This form pertains to Physician/Practitioner prescribed medication **and** over-the-counter medications.*
This form needs to be completed each school year. Only one student per form.

Box 1 – Over the Counter –Non-prescription medication will only be administered in accordance with product instructions. If the student requires dosing different than manufacturer's instructions, a practitioner order AND signature is required.

Box 2 – Practitioner Prescribed Medication - Your Practitioner needs to fill out the top portion and the information in Box 2 with any prescribed medications that may be administered during the school day/activities. He/She needs to sign and date the bottom in the Prescribed Medication Section. (**Please note** – EPIPEN, INSULIN, DIASTAT require an additional form).

ALL MEDICATIONS MUST BE TRANSPORTED TO AND FROM SCHOOL BY A PARENT/GUARDIAN.

Please administer the following medication(s) to:

Name of Student	DOB	Ht	Wt	Grade
Diagnosis(s)	Allergies			
Current medication(s) taken at home:				

· All medications must be brought in from home in the unopened original containers, and securely stored in the cabinet in the school health room.
· Instructions may not exceed the manufacturer's recommended dosages.

BOX 1 - OVER-THE COUNTER/AS NEEDED MEDICATION (Must be given as directed on medication box):				
Name of Medication	Dose (Must be given as directed)	Time or As Needed	Route	Reason
Duration of time medication is needed and any additional Information/Instructions::				
Parent Signature		**Date:**		

BOX 2 - PRACTITIONER PRESCRIBED MEDICATION (INCLUDING OVER THE COUNTER MEDICATION BEING USED OTHER THAN DIRECTED ON BOX): ☐ Please check box if student may self-carry inhaler. ☐ Please check box if student may self-carry epi-pen. **(If self-carrying, we still need an epi-pen in health room.)** Name of Medication Dose Time/Frequency/EndDate			Route	Direct contact shall be made with MD/NP should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, state none)
Hospital/Clinic/Office:			Phone Number:	
Physician/Practitioner Printed Name:			Fax Number:	
Physician's Signature (required for MD/NP prescribed medicine)			**Date:**	
Parent's Signature			**Date:**	

Guardian, please **check those that apply:**

_____ Authorized school personnel have my permission to administer the prescription and/or non-prescription medication(s) to my child as described above.

_____ My child has my permission to carry and self-administer the above prescribed *epi-pen* and/or *inhaler*.

I AGREE TO HOLD THE HOLY HILL AREA SCHOOL DISTRICT, ITS EMPLOYEES AND AGENTS WHO ARE ACTING WITHIN THE SCOPE OF THEIR DUTIES HARMLESS IN ANY AND ALL CLAIMS ARISING FROM THE ADMINISTRATION OF MEDICATION AS DESCRIBED ABOVE AT SCHOOL. I HEREBY GIVE PERMISSION TO THE SCHOOL NURSE TO CONTACT THE PHYSICIAN AS NEEDED.

I understand that for safety reasons, ALL medication (prescription or non-prescription) have to be in the original container. I further understand that it is my responsibility to inform the school nurse of any changes to my child's medications. I give permission to the school nurse to contact my student's physician.

Parent/Guardian Signature: _____ Date: _____

School Nurse Approval: _____ Date: _____

Staff Member(s) authorized to administer the above described medication(s)/treatment(s): _____

_____

Medication Authorization is only valid for the school year in which the date signed falls within. Questions?
~Friess Lake School 262-628-2380 ~Richfield School 262-628-1032