Aldo Leopold Charter School

Authorization Form for Administering Medications at School

Medications will be administered in the school ONLY when it is necessary for the student to remain in school. Parents are invited to come to school to administer their children's medications. If school personnel are requested to keep medication (both prescription and non-prescription) for emergency administration, or when it is necessary for a child to take medication during school hours, this authorization form (valid for current school year) must be signed by a parent/guardian and the prescribing practitioner.

The purpose of this policy is to ensure that students do receive necessary medications according to their health care provider's orders and to ensure maximum safety for all concerned. **Please respond to all items**.

Student Name _____ Date of Birth _____

School _____ Teacher _____ Grade _____

Parent/ Guardian Name _____ Daytime Phone Number _____

TO BE COMPLETED BY PRESCRIBING PRACTITIONER:

1. I have examined this student for (diagnosis) _____and have determined she/ he requires medication during school hours. ICD-9 code(s) _____ [*required for Medicaid purposes*.]

2. Name of medication and dosage _____ Route _____
   Generic substitution is permitted _____YES _____NO

3. Time(s) of administration:

4. Duration of time student is expected to be receiving this medication:

5. Special instructions regarding this medication (include requests for periodic screenings):
6. Contact me if the following signs or symptoms appear:

7. Options for administration (check one):

___ Student may <u>carry and self-administer</u> medication (excluding controlled substances) without supervision. I believe this student is capable of taking the medication at the appropriate time and in the appropriate way. Students are encouraged to bring a single or metered dose daily.

___ Student's age or disability prevents she/he from self-administration, requiring administration by the Nurse or Certified Health Assistant according to practitioner's instruction.

___ Student may <u>self-administer under direct supervision</u> of authorized, trained school personnel. Medication will be kept locked in the Nurse's Office.

Practitioner's signature _____ Date _____

PARENT/GUARDIAN STATEMENT:

I hereby request a school employee to administer or assist and supervise in the self-administration of the above medication as prescribed. I agree to:

1. Provide the above medication and replacement medication as necessary.
2. Provide the school with the original containers (pharmacy –labeled for prescription meds.)
3. Provide a new authorization form for new medications or changes and notify the school nurse if discontinued.
4. Give permission for the transfer of medical information regarding my child's condition, which requires the administration of this medication, between the school and the prescribing practitioner.

Parent/ Guardian signature _____ Date _____

School nurse signature _____ Date _____

Principal's signature _____ Date _____

Date medication discontinued per: Parent _____ (Practitioner notified by _____/ date_____)
Date medication discontinued per: Practitioner _____ _ (Nurse signature _____)

Revised 8/2012
SCS 1017