



WEST MICHIGAN ACADEMY
OF ENVIRONMENTAL SCIENCE

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SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year 2018/2019 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.**
- **Non-prescription medication must be in the unopened, original container with the label intact.**
- **An adult must bring the medication to the school.**
- **A PHYSICIAN'S SIGNATURE IS NEEDED FOR BOTH PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS.**

PARENT / PRESCRIBER'S AUTHORIZATION

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Form of Medication: _____ Tablet/Capsule _____ Liquid _____ Inhaler Other _____

Time/frequency of administration: _____

Relevant side effects: None expected _____ Yes/Specify _____

Medication shall be administered from: / / to / /

Prescriber's name: _____

Telephone: _____ Fax: _____

Prescriber's address: _____

Prescriber's Signature: _____ Date: _____

PARENT / GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. **I authorize designated school personnel 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 MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of medication (including emergency medication) must be authorized by the prescriber.

Prescriber's authorization for self-carry/self-administration of medication: _____

Signature

Date

Parent/Guardian's authorization for self-carry/self-administration of medication: _____

Signature

Date