

## Tri-State Christian Academy Medication Administration Authorization Form

This order is valid only for school year (current) \_\_\_\_\_.

This form must be completed fully in order for Tri-State Christian Academy 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 and pick it up at the end of the year or it will be discarded.
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child or the child's medication
- Students may self-carry emergency medications if authorized by the prescriber below (see attached policy)

### **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: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

### **PARENT/GUARDIAN AUTHORIZATION**

I request TSCA personnel to administer the medication as prescribed by the above prescriber. I agree to advise the school in writing of any changes in my child's condition with respect to the physician ordered administration of medication or with any changes to the information provided on the form. I understand that it is my responsibility to send an appropriate supply of medication to school in its original container. ***(Medication not provided in an original container will not be accepted)*** I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I understand that the school will have limited liability while administering medication to my child in accordance with the Prescriber's Authorization. The school agrees to keep a written log of medication administered to my child in school throughout the current year. I 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 MEDICATION AUTHORIZATION/APPROVAL**

Self-carry/self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the TSCA medication policy and the state medication policy.

Prescriber's authorization for self-carry/self administration of **emergency medication**: \_\_\_\_\_  
Signature Date

School RN approval for self-carry/self administration of **emergency medication**: \_\_\_\_\_  
Signature Date

Order reviewed by the school RN: \_\_\_\_\_  
Signature Date