



HAMPSHIRE COUNTY SCHOOLS

HEALTH SERVICE

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Student's Name: _____

Date: _____

School: _____

Birth Date: _____

Parent's Phone #: _____

Grade: _____

This form must be filled out and signed by a licensed prescriber and the parent/guardian for any prescribed and over the counter medication to be given in the school setting. A separate order is required for each medication and orders are good for the current school year only. All medication changes (dosage, time, etc.) require the completion of another form. A photograph of this student may be taken to assist in the correct administration of medication. Unlicensed school personnel to whom the nurse has delegated medication administration and trained to administer medication may give medication. All medication must be sent to school in the original container bearing the student's name.

Name of Medication: _____

Reason for Medication Administration: _____

Dosage: _____ Route or method of administration: _____

Time/s to be administered: _____

Side effect to watch for: _____

Comments/Special Instructions: _____

Student Allergies: _____

* If rectal Diazepam or intranasal Valtoco or intranasal Nayzilam may this medication be administered by unlicensed personnel? Yes or No (Circle one)

*May this student self-administer this medication if permitted by county policy? Yes or No (Circle one)

*May this student carry this medication on his/her person if permitted by county policy? Yes or No (Circle one)

Prescriber's Name (please print) _____ Telephone Number: _____

Prescriber's Address: _____ Fax Number: _____

Prescriber's Signature: _____ Date: _____

I understand that, whenever possible, all medications should be given at home. I give permission for _____ to take the above medication at school according to county policy. I also understand and agree that the school nurse may talk with the clinician and his or her staff, as well as school personnel, regarding the student's condition and administration of this medication and its effects.

Parent/Guardian signature to approve administration of medication:

Day time phone number: _____ Date: _____