Wentzville School District
Prescription Medication Authorization Form

School: _____ **Phone:** _____ **Fax Number:** _____

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

Medication Name: _____

Dose: _____

Route: ☐PO ☐Inhaler ☐Injection ☐Rectal ☐ Other: _____

Time: ☐ Daily: _____ (time given) ☐ PRN: _____ (time given)

Frequency: _____

Relevant Side Effects: ☐ None Expected Specify: _____

_____

Medication shall be administered from: ____/____/____ (month/day/year) to ____/____/____ (month/day/year)

PHYSICIAN AUTHORIZATION

Prescriber's Name/Title: _____

Telephone: _____ **Fax:** _____

Prescriber's Signature: _____
(MD, NP, Or PA signature or signature stamp ONLY)

Date: ____/____/____

Use for Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication 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 the school nurse to communicate with the healthcare provider as allowed by HIPAA.

Parent/Guardian Signature: _____ **Date:** ____/____/____

Would like medication administered on:

Late Start Days: YES / NO	**Early Release Days:** YES / NO	**Field Trips:** ON TRIP / AFTER TRIP / NO

*SELF-CARRY/SELF-ADMINISTRATION OF **EMERGENCY** MEDICATION AUTHORIZATION/APPROVAL*

Self-carry/self-administration of emergency medication for **asthma** or **anaphylaxis** may be authorized by the prescriber and must be approved by the school nurse according to the medication policy.

Prescriber's auth for self-carry/self-administration of emergency med: _____ (Signature) ____/____/____ (Date)

Parent/Guardian auth for self-carry/self-administration of emergency med: _____ (Signature) ____/____/____ (Date)

Prescription medication must be in a container properly labeled by pharmacist or prescriber. An adult must bring the medication to school. The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or medication.

Order reviewed and received by School Nurse: _____ Date: ____/____/____