

ARIZONA CULTURAL ACADEMY & COLLEGE PREP

Prescription Medication Administration Consent Form

This order is valid only for school year (current) _____ 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 original container with the label intact.

*An adult must bring the medication to the school.

* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the student and /or the student's medication.

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: (Date) _____ to (Date) _____

Prescriber's Name/Title: _____ Signature: _____

Address: _____

Telephone: _____ Fax: _____

A verbal order was taken by the school RN (Name): _____ for the above medication on Date: _____

Parent/Guardian Authorization

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

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____