Academia de Mi Abuela School Health Program

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian and Physician:

We discourage the administration of medication in the school setting and request that whenever possible medications are schedule during non-school hours. If medication is needed while in school, the following requirements must be met on the first day that the student is to receive medication:

1. No medication will be administered without the parent's/guardian's signed consent and the physician's written medication authorization order. This will be kept on file in the Student's Health Record. The parent/guardian is responsible for obtaining the required information from the physician.
2. A separate parent/guardian consent form and physician's medication authorization order must be on file for each medication a student is to receive at school.
3. The medication must be properly labeled by the pharmacist. The label must include: Name of student, name of medication, date, dosage and time of administration, and directions for administration.
4. All medications must be brought to school by the parent/guardian and given to authorized personnel.
5. The parent/guardian is responsible for submitting to the school, written permission from the physician, notification of any change in dosage or time of administration.
6. All medications kept in school will be stored in a secure area accessible only to the authorized personnel.
7. One week after expiration of the physician's order, the unused portion of the medication must be collected by the parent/guardian or it will be destroyed.
8. Parents/Guardians must notify AMA staff in writing if a student is Lactose-intolerant.

NAME OF STUDENT: _________________________________ DOB: __________AGE: _______

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this form.

I hereby request and authorize AMA trained and certified staff to administer prescribed medication as directed by the physician to ______________________________.
STUDENT'S NAME

I have read the procedures required to administer medication and agree to authorize medicine as required to my child.

This medication is a ☐ new or ☐ renewal prescription.

If new prescription, enter date and time the first dose was given at home.

DATE: _______________________ TIME: _____________ A.M./P.M.

______________________________ ___________________________ __________

SIGNATURE OF PARENT/GUARDIAN PRINT NAME DATE

PLEASE TAKE THIS FORM TO STUDENT'S PHYSICIAN FOR COMPLETION

PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: Please complete and sign this form. ☐ Original ☐ Renewal ☐ Change

MEDICATION RELATION: ☐ Asthma ☐ Epipen ☐ Seizure ☐ Other: ________________

NAME OF STUDENT: ____ DOB: _____________________

ADDRESS: ____ TEL. #: ______________________________

DIAGNOSIS: ____

____

NAME OF MEDICATION: ____

DOSE: ____

TIME & CIRCUMSTANCES OF ADMINISTRATION AT SCHOOL: _____________________________________

EXPECTED DURATION OF ADMINISTRATION: ____

POTENTIAL SIDE-EFFECTS OF MEDICINE: ____

CAN A REACTION BE EXPECTED (RASH OR FEVER, ETC)? ☐ YES ☐ NO

If yes, please describe: ____

If any change, please advise in writing immediately.

___________________________________	___________________________________
PHYSICIAN'S SIGNATURE	PLEASE PRINT NAME
___________________________________	___________________________________
TELEPHONE NUMBER	DATE

____

ADDRESS

___________________________________	___________________________________
AUTHORIZED TRAINED A.M.A STAFF	**A.M.A. ADMINISTRATION/DIRECTOR**

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DATE OF COMPLETION

REVISED SEPTEMBER 2016