Smithton R-VI School Medication Administration Authorization Form

Dear Provider,
To provide safe and accurate administration of the requested medication, we would appreciate your completion and return of this form for your patient. Thank you in advance for taking the time to do this. Feel free to contact us with any questions and/or concerns.

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

School Phone:_____ **Fax:**_____

PARENT/GUARDIAN AUTHORIZATION

I authorize the school nurse to administer the above said medication and to communicate with prescriber as needed regarding medication administration at school as allowed by HIPPA for the school year of _____.

Parent/guardian Signature:_____ **Date:**_____

AUTHORIZED PRESCRIBER USE ONLY

MEDICATION:_____**Dosage:**_____**Route:**_____**Frequency:**_____

Diagnosis requiring medication: _____**Time(s) to be given at school:**_____

If PRN or "as needed", please detail frequency and for what symptoms: _____
_____

Potential side effects:_____

Additional directions or instructions for administration:_____

Authorized prescriber's signature:_____ **Date:**_____

Printed prescriber's name:_____ **Phone:**_____

Address:_____