

OLD TAPPAN PUBLIC SCHOOL DISTRICT

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

Medication given at school must meet the following requirements:

- *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 and completed medication form to the school nurse.
- *The school nurse, as allowed by HIPAA, may consult with the prescriber if necessary.

PRESCRIBER'S AUTHORIZATION

Name of student _____ Date of birth _____

Medication name _____

Medication dose _____ Medication route _____

Time/frequency of administration _____

Condition for which medication is prescribed _____

If prn, for what symptoms _____ If prn, frequency _____

Possible side effects _____

Medication shall be administered from _____ to _____

Prescriber certifies that the student is physically fit to attend school and is free of contagious disease.

Prescriber certifies that the student would not be able to attend school unless medication can be administered during school hours.

Prescriber's name/title _____

Telephone _____

Address _____

Prescriber's signature _____ Date _____

PARENT AUTHORIZATION

I give permission for the school nurse to administer the medication as prescribed by the above prescriber. I release the Old Tappan Board of Education, its Agents, servants and employees from any and all liability related in any manner to the administration of said medication. I certify that I have the legal authority to consent to medical treatment for the student named above.

Signature of parent or guardian _____ Date _____

SCHOOL PRINCIPAL APPROVAL _____ Date _____