MEDICATION AUTHORIZATION FORM

St. Pius CatholicX School

Student's Name _____ **Birthdate**____ **Grade**____ **Teacher** _____

Primary Care Provider _____ **Phone Number** _____

Pharmacy _____

Name of Medication _____

Diagnosis (What is the medication for?) _____

_____

_____

Amount to be given _____ **Time to be given** _____

Is this medication to be given "as needed" ◯ **OR at a specific time** ◯ **(please check one)**

Starting date _____ **Ending date** _____

Amount sent to school _____

I request that the prescribed drugs or medication be dispensed according to these written instructions. I request that a qualified staff person give this medication. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

Parent signature _____ **Date** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IF IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

SUGGESTION: WHEN YOU PICK UP YOUR PRESCRIPTION ASK YOUR PHARMACIST FOR A BOTTLE LABELED FOR SCHOOL USE.

_____ **School Nurse / Administration** _____

Medication Received Signature: _____ **Amount / Count:** _____ **Date:** _____

Medication Returned Signature: _____ **Amount / Count :** _____ **Date:** _____

Medication Disposed Signature: _____ **Amount / Count :** _____ **Date:** _____

Individual Student Medication Record

Student Name: _____ Age: _____ Grade: _____ Room #: _____ Allergies: _____

Parent Phone #: _____ Emergency Contact: _____

Med 1: _____ Dr. Rx: _____ Dr. Phone #: _____ Dose/Route: _____ Time: _____

Med 2: _____ Dr. Rx: _____ Dr. Phone #: _____ Dose/Route: _____ Time: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug.																															
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
Mar.																															
Apr.																															
May																															
June																															

Codes: (X) Weekend (H) Holiday (E) Early Dismissal (S) Snow Day (N) No Medication Available (W) Dose Withheld (A) Absent (P) See Progress Notes on Back

Signature Person Administering	Title	Initials	Date

Medication Returned Date Initials

Medication Destroyed Date Initials

Amt. Rec'd. Date Initials	Amt. Rec'd. Date Initials

*Note documentation of possible medication side effects, physician contact, unusual circumstances, and parental notifications is found in the student medication progress notes on reverse.

Heartland

1-08319