Harvest Christian Academy Medication Administration Authorization Form

School year: _____

This form must be completed fully for HCA 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 mediation must be in the 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 mediation to the school and pick it up at the end of the year or it will be discarded.
- Students may carry self-carry emergency medications if authorized by the prescriber below.
- The school's Administration will call the prescriber, as allowed by HIPAA, if a question arises about the child or child'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: _____

Relevant side effects: __None expected __ Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____

Telephone:_____ Fax:_____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original Signature or Signature stamp only) (Use for Prescriber's Address Stamp)

PARENT/GUARDIAN AUTHORIZATION

I request HCA personnel to administer the mediation as prescribed by the above prescriber. I agree to advise the school in writing of any changes in my child's condition with respect to the physician ordered administration of medication or with any changes to the information provided on the form. I understand that it is my responsibility to send an appropriate supply of medication to school in its original container. **(Medication not provided in an original container will not be accepted**). I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I understand that the school will have limited liability while administering medication to the child in accordance with eh Prescriber's Authorization. The school agrees to keep a written log of medication administered to my child in school throughout the school year. I authorize school administration to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____
Home Phone # Cell Phone # _____ Work Phone # _____

SELF-CARRY/SELF- ADMINISTRATION OF MEDICATION AUTHORIZATION /APPROVAL

Self-carry/self-administration of emergency medication may be authorized by the prescriber and must be approved by the school administrator according to HCA medication policy and the state medication policy.

Prescriber's authorization for self-carry/self-administration of **emergency medication**: _____
Signature Date

School Administrator approval for self-carry/self-administration of **emergency medication**: _____
Signature Date

Received in office: _____