SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

School Year 2022-2023

Bay City Academy 301 N Farragut St Bay City MI 48708 989-414-8254 / Fax 989-321-2225

This order is valid only for the school year 2021-2022 including the summer session for Bay City Academy.

Name of Student: _____ Date of Birth:_____
Grade: _____
Condition for which medication is being administered: _____
Medication Name: _____Dose: _____
Time/frequency of administration: _____
If PRN, frequency: _____ If PRN, for what symptoms:_____
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)

PARENT/GUARDIAN AUTHORIZATION
I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse 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 medication (including emergency medication) may be authorized by the prescriber and must be approved by the school nurse according to the School Nurse Program medication policy.
Prescriber's authorization for self carry/self administration of medication:_____

Signature_____ Date _____
School RN approval for self carry/self administration of medication:

Signature_____ Date _____
Order reviewed by the school RN:
_____