Policy 4.1.8.8
Form 4188A

HAMPSHIRE COUNTY SCHOOLS
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Student's Name: ______________________ **Date:** ______________

School: ______________________ **Birth Date:** ______________

Parent's Phone#: ______________________ **Grade:** ______________

This form must be filled out and signed by a licensed prescriber and the parent/guardian for any prescribed and over the counter medication to be given in the school setting. A separate order is required for each medication and orders are good for the current school year only. All medication changes (dosage, time, etc.) require the completion of another form. A photograph of this student may be taken to assist in the correct administration of medication. Unlicensed school personnel to whom the nurse has delegated medication administration and trained to administer medication may give medication. All medication must be sent to school in the original container bearing the student's name.

Name of Medication: ______________________

Reason for Medication Administration: ______________________

Dosage: ______________ Route or method of administration: ______________

Time/s to be administered: ______________________

Side effect to watch for: ______________________

Comments/Special Instructions: ______________________

Student Allergies: ______________________

* If rectal diazepam, may this medication be administered by unlicensed personnel? Yes or No (Circle one)
*May this student self-administer this medication if permitted by county policy? Yes or No (circle one)
*May this student carry this medication on his/her person if permitted by county policy? Yes or No (circle one)

Prescriber's Name (please print) ______________________ Telephone Number: ______________

Prescriber's Address: ______________________ Fax Number: ______________

Prescriber's Signature: ______________________ Date: ______________

I understand that, whenever possible, all medications should be given at home. I give permission for ______________________ to take the above medication at school according to county policy. I also understand and agree that the school nurse may talk with the clinician and his or her staff, as well as school personnel, regarding the student's condition and administration of this medication and its effects.

Parent/Guardian signature to approve administration of medication: ______________________

Day time phone number: ______________________ **Date:** ______________