

Cornerstone Christian Academy

School Medication Administration Authorization Form

This order is valid only for school year (current) _____ including the summer session.

This form must be completed fully in order for school 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 a medication.

*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 to the school

AUTHORIZATION

Name: _____ DOB: _____ Class: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of administration: _____ PRN/frequency: _____

If PRN, for what symptoms: _____

Side effects: none expected or please specify: _____

PARENT/GUARDIAN AUTHORIZATION

I request CCA staff to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I 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: _____

Order reviewed by the school RN: _____ Date: _____

