Ludington Area School District
Medication Administration Authorization Form

This authorization is only valid for the current school year: _____ including the summer session.

This form must be completed fully for LASD to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each student, for each medication, and each time there is a change in dosage or time of administration of the 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 factory label intact.
- An adult must bring the medication to school, unless pre-arranged with district staff.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.
- **Over the counter medications do not need prescriber's signature per LASD Board Policy.**

Prescriber's Authorization

Student Name: _____ **Student DOB:** _____ **Grade:** _____

Condition medication is being administered for: _____

Medication Name: _____ **Dose:** _____ **Route:** _____

Flush details and volume, if applicable: _____

Time/Frequency of Medication: _____ **If PRN, frequency:** _____

If PRN, for what symptoms: _____

Relevant Medication Side Effects: □ **None expected** □ **Specify:** _____

Medication Duration: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title (Printed): _____

Telephone: _____ **Fax:** _____

Address: _____

_____

Prescriber's Signature: _____ **Date:** _____
(Original Signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

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 Signature: _____ **Date:** _____

Daytime Contact Number: _____

Self-Carry/Self-Administration of Medication Authorization/Approval

Self-carry/self-administration of medication (including emergency medications) may be authorized by the prescriber and must be approved by the school nurse.

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/Authorization Reviewed by School RN: _____
Signature Date