Medication Administration Authorization

ACADEMY OF HOLY ★ ANGELS

Student Name: _____Birthdate: ____/____/____ Grade: _____ School Year: _____

Please read this form carefully as there are different requirements for prescription and non-prescription medication. Medications will not be administered if forms are incomplete. All medications must be supplied in the original medication bottle (you may ask the pharmacy to split medication between two labeled bottles). Controlled medications such as stimulants MUST be brought to the school by a parent or guardian.
Students may self-carry and self-administer *non-prescription pain medication* (excludes medications containing ephedrine or pseudoephedrine) without the completion of this form if the parental authorization sent through myAHA has been signed.

The following medication requested to be administered is (please check):

☐ Prescription: Licensed prescribing provider completes Sections A&B. Parents/guardians complete Section C.

☐ Non-Prescription: Parents/ guardians complete Sections A&C. Section B to be left blank.

SECTION A- Medication Details

Medication Name: _____ Dose & time of administration _____

Start date: _____ End date: _____ (authorizations expire at the end of the school year)

Purpose or condition for which medication is prescribed: _____

Possible side effects: _____

Comments: _____

SECTION B - Licensed Prescribing Provider to Complete (Prescription Medications Only)

The student may carry and self-administer the above named medication (ex- inhaler, EpiPen, migraine med.) Yes ☐ No ☐

_____ _____

Print or Type Name of Physician/Licensed Prescriber Physician's/Licensed Prescriber's Signature

_____ _____ _____

Clinic Address Phone Number Date

SECTION C - Parent/Guardian Request for Medication Administration

I request that the above listed medication be administered as prescribed. If necessary, the school may request additional information from the licensed prescribing physician regarding this medication/ condition. I will be asked to pick-up or have my student pick-up all remaining medications at the end of the school year (controlled medications MUST be picked up by a parent/guardian). I acknowledge that a student's permission to self-carry and/or self-administer medication will be revoked if a student is not using the medication as directed. Student's may NOT share any medications.

☐ I request this medication be administered by AHA Health Services.

☐ I give permission for my student to self-carry and self-administer the medication (not applicable for controlled medications).

_____ _____ _____

Parent/Guardian Signature Date Telephone