

SHENANDOAH VALLEY ACADEMY
PRESCRIPTION MEDICATION ADMINISTRATION AUTHORIZATION FORM
234 West Lee Highway New Market, Virginia 22844
Phone: (540) 740-3161 ~ Fax: (540)740-3336

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

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each 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.
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

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: _____ (Type or print) Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

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 EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____

Signature Date

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

Signature Date

Order reviewed by the school RN: _____

Signature Date