ROSWELL INDEPENDENT SCHOOL DISTRICT
HEALTHCARE PROVIDER ORDER AND MEDICATION AUTHORIZATION FORM

- **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 medication.**
- **Prescription medication must be in a CURRENT container labeled by the pharmacist or prescriber.**
- **The school nurse will call the prescriber if a question arises about the child and/or the child's medication.**

Student's Name: _____

Date of Birth _____School: _____ Allergies: _____

HEALTH CARE PROVIDER'S ORDER

1. I have examined this student for (diagnosis) _____ and have determined she/he requires medication during school hours. ICD-10 Code_____
2. Name of medication: _____ Dosage: _____
3. Route: _____Time of administration: _____
4. This student is expected to be receiving this medication (how long): _____
5. Special instructions regarding this medication: _____
6. Contact me if the following signs or symptoms appear:_____
7. While on a field trip, student will be able to self-administer one dose of prescribed medication under the supervision of a teacher at the appropriate time and manner. Yes _____ No _____.

Physician's signature _____Printed name _____

Date _____ Phone_____

PARENT/GUARDIAN STATEMENT

1. I, the undersigned parent/guardian of_____ request that a school nurse or trained designee administer the above medication to the student, according to the health care provider's instruction. I agree to furnish the necessary prescribed medicine in the properly labeled container, to provide replacement medication as necessary, and I agree to notify the school nurse immediately if the medication prescription or dosage is changed.
2. I, the undersigned parent/guardian of _____give my permission for my child to self-administer one dose of prescribed medication under the supervision of a teacher at the appropriate time and manner while attending a field trip.
3. I authorize, as needed, the sharing of information related to my child's health between the school nurse and the healthcare provider listed on this form.

Parent/Guardian signature _____ Initials:_____ Date:_____

Home:_____ Cell: _____Work: _____

Parent must initial any special directives added in the space below:

_____ I will pick up any unused medication on the last day of school.
Parent Initials

_____ Please send home any unused medication with my child on the last day of school.
Parent Initials I assume all liability in the transport of the medication via my child. (NOT APPLICABLE FOR ELEMENTARY STUDENTS)

_____ Please discard any unused medication on the last day of school per Board of Pharmacy Regulations.
Parent Initials

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