Serving age 18-months through Grade 12

2018/2019

OVERNIGHT SCHOOL SPONSORED ACTIVITIES ONLY

Self-Administration of Medication Authorization Form
Grades 9-12

13500 Layhill Road, Silver Spring, MD 20906
301-576-2800 fax: 301-576-2805 www.barrie.org

This form must be completed fully and on file in the health office in order for a student to self-administer medication(s) during school sponsored **OVERNIGHT** activities, including Extended Study Week (ESW). This form is required for each medication.

- All prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the unopened original container with the label intact.

The School Nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the student and/or the student's medication(s).

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: ____

Medications shall be administered from: ________________________________ to: _______________________________
Month/Day/Year Month/Day/Year

Prescriber's Name: ____

Telephone: ______________________ Fax: ______________________

Address: ____

____

Self-carry/self-administration of medication must be authorized by the prescriber and be approved by the School Nurse according to the Barrie School Medication Policy prior to medication administration.

Prescriber's Signature: ____ Date: _________________________
(Original signature or signature stamp ONLY) Month/Day/Year

Parent/Guardian Authorization

I/We request that our student self-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 self-administration of medication. 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: _______________________

Reviewed and approved by School Nurse: ____ _____________________
Signature **Date**