JMMS FIELD TRIP

Form: 2

ONLY RETURN IF STUDENT NEEDS PRESCRIPTION MEDICATION DAY OF TRIP

Jackson Local Schools

Prescription Medication Administration Authorization

Student's Name:_____ DOB:_____

Grade:_____ Building:_____ Teacher:_____ School Year:_____

Medication Allergies/Interactions:_____

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 school year, for each medication, and each time there is a change in dosage or time of medication administration.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original packaging with the label intact and contain the student's name**.**
- A parent/guardian **must** bring the medication to school. Students **are not** permitted to bring medication to school.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or child's medication.

♦PRESCRIBER'S AUTHORIZATION♦

(this section must be completed by the prescriber)

Condition for which medication is being administered:_____

Medication:_____ Strength:_____ Dose:_____

Amount:_____ Route:_____ Time:_____ If PRN, frequency:_____

If PRN, for what symptoms:_____

Relevant side effects: □ None expected □ Specify:_____

Medication administration begin date:_____Medication administration end date_____

**Note: orders are only valid length of field trip*

Prescriber's Name/Title:_____Telephone:_____Fax:_____

Address:_____

Prescriber's Signature:_____Date:_____

(Original signature or signature stamp ONLY)

A verbal order was taken by the school nurse, _____ for the above medication on _____

(name) (date)

♦PARENT/GUARDIAN AUTHORIZATION♦

I/We authorize 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 the medication must be in the ***original*** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate. I/We understand that at the end of the school year, an adult must pick up the medication; otherwise it will be properly discarded. I/We authorize the school nurse to communicate with the health care provider/prescriber or pharmacist to clarify the above listed medication order as allowed by HIPAA.

Parent/Guardian Signature: _____ Date:_____

Contact Phone #1:_____ Contact Phone #2:_____

Relationship to Student: □ parent □ legal guardian □ other:_____(needs written/verbal permission)

Order reviewed by the school nurse: _____ _____

Signature Date