PORTSMOUTH STEM ACADEMY
614 3rd Street
Portsmouth, OH 45662
740.351.0591 (Office) 1.740.879.2039 (Fax)
www.portsmouthacademy.org

School ***Prescription Medication*** Administration Authorization Form

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 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 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 Medication Administrator 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:____ DOB:____________

Condition for which medication is being administered:________________________________

Medication Name:______________________________ Dose:________________

Time/Frequency of administration:________________________________

If when needed, for what symptoms:________________________________

Relevant side effects - None expected_______ Specify:________________________

Medication shall be administered from:____/_____/_____ to ____/____/_____

Prescriber's Name/Title:________________________________

Phone:______________________ FAX:______________________

Address:______________________ City________________ Zip__________

Prescriber's Signature:________________________________

Parent/Guardian Authorization

I 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 Medication Administrator to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:______________________________ Date_____/______/_____

Home Phone:________________ Cell________________ Work________________

For Office Use -- Received by Medication Administrator _____/_____/______