DEPARTMENT OF HEALTH

School Health Program

AUTHORIZATION FOR MEDICATION ADMINISTRATION FORM

NAME OF STUDENT: _____ **DOB:** _____

SCHOOL: _____ **SOC. SEC. #**_____ **Grade:** _____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse/Licensed Practical Nurse/Trained Certified DCPS Personnel to administer prescribed medication as directed by the physician to _____.
STUDENT'S NAME

I have read the procedures on the reverse side of this form and agree to assume the responsibilities as required.

This medication is a ☐ new or ☐ renewal prescription. If new prescription, enter date and time the first dose was given at home.

Date: _____ Time: _____ A.M/P.M.

_____ _____
SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP

_____ _____
PLEASE PRINT NAME DATE

PLEASE TAKE THIS FORM TO STUDENT'S PHYSICIAN FOR COMPLETION

PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: Please complete and sign this action. ☐ Original ☐ Renewal ☐ Change

NAME OF STUDENT: _____ DOB::_____

ADDRESS: _____ TEL. NO.:_____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSE::_____

TIME & CIRCUMSTANCES OF ADMINISTRATION AT SCHOOL: _____

_____

EXPECTED DURATION OF ADMINISTRATION: _____

CAN REACTION BE EXPECTED? ☐ Yes ☐ No If yes, please describe: _____

If any change, please advise in writing immediately.

_____ _____
PHYSICIAN'S SIGNATURE ADDRESS

_____ _____ _____
PLEASE PRINT NAME TELEPHONE NO. DATE

_____ _____
SCHOOL NURSE DCPS TRAINED STAFF

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

School Health Program

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian and Physician:

We discourage the administration of medication in the school setting and request that whenever possible medications are scheduled during non-school hours. If medication is needed while in school, the following requirements must be met on the first day that the student is to receive medication:

1. No medication will be administered without the parent's/guardian' signed consent and the physician's written medication authorization order. This will be kept on file in the Student's Health Record. The parent/guardian is responsible for obtaining the required information from the physician.

2. A separate parent/guardian consent form and physician's medication authorization order must be on file for each medication a student is to receive at school.

3. The medication must be properly labeled by the pharmacist. The label must include: a.) Name of student's name, b.) Name of medication, c.) Date, d.) Dosage and time of administration, and e.) Directions for administration.

4. The first day's dosage of any new medication must be given at home.

5. All medications must be brought to school be the parent/guardian and given to authorized personnel.

6. The parent/guardian is responsible for submitting to the school, in writing from the physician, notification of any change in dosage or time of administration.

7. All medication kept in school will be stored in a secure area accessible only to authorized administering personnel. (Such storage will be at the risk of the parent/guardian). The school nurse nor District of Columbia Public Schools (DCPS) personnel will assume any responsible for possible loss of students' medication.

8. One week after expiration of the physician's order, the unused portion of the medication must be collected by the parent/guardian or it will be destroyed.

9. DCPS personnel nor the school nurse will assume any responsibility for non-medically prescribed medication or medication self-administered by the student.

10. Parents/guardians must let DCPS and the school nurse know in writing if a student is Lactose-intolerant.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

School Health Program

AUTHORIZATION FOR MEDICAL PROCEDURE/TREATMENT

NAME: _____ **DOB:** _____

SCHOOL: _____ **SSN#:** _____

TEACHER: _____ **GRADE:** _____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse (RN, LPN, Nurse's Aide, Technician) or a trained DCPS employee to perform _____
SPECIFIC MEDICAL PROCEDURE/TREATMENT

on my child_____ **as prescribed by the physician below.**

I have read the information on the reverse side of this form and agree to assume responsibilities as required.

_____ _____
SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO CHILD

_____ _____
PLEASE PRINT DATE

PART II: PHYSICIAN'S SPECIFIC MEDICAL PROCEDURE/TREATMENT AUTHORIZATION ORDER

Physician: Please complete and sign this action.

NAME: _____ **DOB:** _____

ADDRESS: _____ **PHONE:** _____

DIAGNOSIS: _____

SPECIFIC PROCEDURE/TREATMENT: _____

TO BEGIN ON: _____ **AND END ON**_____
DATE DATE

REASON FOR PROCEDURE/TREATMENT: _____

INSTRUCTIONS: _____

PRECAUTIONS: _____

POSSIBLE ADVERSE REACTIONS: _____

_____ _____
PHYSICIAN'S SIGNATURE PLEASE PRINT

_____ _____
ADDRESS PHONE

_____
SCHOOL NURSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

School Health Program

AUTHORIZATION FOR SPECIFIC MEDICAL PROCEDURE/TREATMENT

Dear Parent/Guardian and Physician:

Students in need of specific medical procedures/treatments during school hours must meet the following requirements:

1. Parents/guardians must present to the principal and school nurse a signed consent and physician's written authorization for the procedure/treatment. The physician's authorization and parent's consent will be maintained in the Student Health Record.

2. The parent/guardian's signed consent and physician's authorization must be in place before the student receives the specific medical procedure/treatment.

3. The physician's authorization must include: the student's name, date of birth, address, telephone number, diagnosis, name of procedure/treatment, reason for and any precautions or possible adverse reactions to the procedure/treatment that authorized personnel may expect.

4. The parent/guardian must meet at school with the principal, school nurse and other authorized school personnel to initiate the specific medical procedure/treatment.

5. Supplies to provide a specific medical procedure/treatment must be provided by the parent/guardian. All equipment and supplies that are required must remain in the school if possible.

6. Physician authorization for specific medical procedures/treatments must be renewed at the beginning of each semester and summer school if the student continues to need the procedure/treatment.

7. If any adjustments (i.e., technique, frequency, medications) are made, a new Physician Authorization, and Parental Consent Form will be required.

8. All equipment and supplies kept in the school will be stored in a secured area accessible only to authorized administering personnel. Such storage will be at the risk of the parent/guardian. Children's National Medical Center School Health Program personnel (CNMC School Nurses) and District of Columbia Public School personnel (DCPS trained persons) assume no responsibility for possible loss of or damage to equipment and supplies.

9. One week after expiration of the physician's order, the equipment and unused portions of the supplies must be collected by the parent/guardian, or they will be discarded.

10. CSS personnel and DCPS personnel assume no responsibility for non-medically prescribed procedures/treatments or those self-administered by the student.