Washington County School District Health Services

MULTIPLE MEDICATION ADMINISTRATION AUTHORIZATION

STUDENT:	SCHOOL:	GRADE:	DOB:
ADDRESS:		STATE:	ZIP:
MEDICAL HISTORY:			
KNOWN ALLERGIES:			

TO BE FILLED OUT OR REVIEWED BY THE PRESCRIBING PRACTITIONER:

MEDICATION:_____

Dose:_____Time_____

Route: □Oral □Inhalant □Injection
□Nasogastric Tube □Gastrostomy Tube
□Other_____

Reason for medication_____
Can child self-administer this medication?_____
Is medication needed in his/her possession?_____
Potential adverse side effects:_____
Refrigeration Needed: ☐ Yes ☐ No

MEDICATION:_____

Dose:_____Time_____

Route: □Oral □Inhalant □Injection
□Nasogastric Tube □Gastrostomy Tube
□Other_____

Reason for medication_____
Can child self-administer this medication?_____
Is medication needed in his/her possession?_____
Potential adverse side effects:_____
Refrigeration Needed: ☐ Yes ☐ No

MEDICATION:_____

Dose:_____Time_____

Route: □Oral □Inhalant □Injection
□Nasogastric Tube □Gastrostomy Tube
□Other_____

Reason for Medication_____
Can child self-administer this medication?_____
Is medication needed in his/her possession?_____
Potential adverse side effects:_____
Refrigeration Needed: ☐ Yes ☐ No

MEDICATION:_____

Dose:_____Time_____

Route □Oral □Inhalant □Injection
□Nasogastric Tube □Gastrostomy Tube
□Other_____

Reason for Medication_____
Can child self-administer this medication?_____
Is medication needed in his/her possession?_____
Potential adverse side effects:_____
Refrigeration Needed: ☐ Yes ☐ No

PRECRIBING PRACTITIONER AUTHORIZATION: *I have determined that the above described medications and routes of administration are medically necessary during school hours to maintain this child's physical health.*

Prescribing Practitioner's Signature_____**Date**_____
Office Phone_____**FAX**_____

PARENT/GUARDIAN AUTHORIZATION: *The school authorized personnel have my permission to administer the above medication. I will adhere to the following conditions of this agreement:*

- I will bring this form into the office completed and signed by my health care practitioner before expecting medication to be administered.
- I will bring the medication to school in its original pharmacy-labeled container (or manufacturer's container if over-the-counter), and I will maintain the supplies as needed throughout the year, or until discontinued.
- I will renew this authorization every time there is a change of any kind regarding the medication, the information in this form, and/or the pharmacy label.
- I will pick up the unused medication when it has been discontinued, and at the end of the school year. If I do not pick it up within 5 days I will allow the authorized personnel to dispose of it.

Parent/Guardian Signature_____**Date**_____
Home Phone_____ **Emergency phone** _____