SANTA FE INDIAN SCHOOL HEALTH CENTER

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

PART I – TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize designated and properly instructed school personnel to administer prescribed medication as directed by the prescribing physician (PART II below). I certify that I have legal authority to consent to the administration of prescribed medication following the physician's order. I understand additional prescriber/parent authorizations will be necessary for each medication to be administered, and if the dosage off the medication is changed. If necessary, I authorize **the designated school health care official to communicate with the prescriber or the student's health care provider as allowed by HIPAA.**

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____ Gender: M____ F___

LAST M. FIRST

Grade: _____ School Year: _____ Height (inches): _____ Weight(lbs.) _____

List all medication(s) student is taking, including over the -counter medication(s):

_____

_____

List any known drug allergies/reactions:

_____

_____

Parent/ Guardian Signature: _____ Date: _____ Phone #: _____

PART II – TO BE COMPLETED BY THE PROVIDER (PLEASE USE A SEPARATE FORM FOR EACH MEDICATION)

NAME OF MEDICATION: _____ Diagnosis: _____

DOSAGE: _____ Time(s)/ Frequency to be given: _____

Route of Administration _____ PRN: YES ____ NO ____

IF PRN, (SIGNS, SYMPTOMS): _____

Side Effects: _____

Begin Medication Date: _____ Stop Medication Date: _____

Special Instructions:

- Is medication a controlled substance? **YES____ NO____**
- Is this an emergency self-carry/self-administration medication? **YES _____ N0_____**
- Has the student been instructed in the proper self-administration medicine? **YES_____ NO____**
- Refrigeration Required? **YES____NO____**

Prescriber's authorization for self-carry/self -administration of emergency medication: _____

SIGNATURE

Prescriber's NAME/ TITLE (Please Print): _____

Phone Number: _____ Fax: _____

Prescriber's Signature: _____ Date: _____

SFIS HEALTH CENTER NURSE SIGNATURE: _____ Date: _____