TURNING POINTE
AUTISM FOUNDATION

Authorization for Administration of Medication Form

Student Name: Date of Birth: School Year:

Students should not take medication during school hours or during school-related activities unless a licensed health care provider and parent/guardian believe it is absolutely necessary for the critical health and well-being of the student. When a student requires daily or regular medication, every effort must be made to give prescribed doses of the medication at home. Each medication that is to be administered to the student, whether it be a scheduled medication that they will be taking daily or a PRN/over-the-counter medication that they will take only if needed for pain/fever, etc, must have the following prior to our ability to administer the medication:

- Physician/prescriber AND parent/guardian both signed and dated Authorization for Administration of Medication Form
- The medication must be brought into school by the parent/guardian (cannot be sent in backpack or with student in the original labeled container as dispensed or in the manufacturer's labeled container
- The medication label must contain the student's name, the name of the medication, directions for use and the date the medication was filled/ and expires
- The medication label must match the directions for administration specified on the Authorization for Administration of Medication Form
- Annual renewal of Authorization for Administration of Medication Form for each school year and immediate notification, in writing, of any changes per the Administration of Medication Policy and Health and Safety Policy

Physician Authorization

Medication Name/Generic Name of Drug: Controlled Drug: Yes ◯ No ◯

Condition for which drug is being administered:

Specific Instructions for Medication Administration:

Dosage: Route/Method:

Time of Administration: Hour window before/after administration time Other:

If PRN medication, please explain when, how much, how often it may be administered and the expected outcome:

Relevant side effects of medication: None expected ◯

Potential allergies, reaction to/negative interaction with food or drugs:

NOTE: If student may self-administer medication under supervision of Health Service personnel or designee, a student self-administration form must be completed.

Prescriber's Name: Prescriber's Signature: _____

Prescriber's Emergency Phone: Prescriber's Fax:

Prescriber Address: Date:

I give permission for the exchange of information between the prescriber and the school nurse to ensure the safe administration of this medication. Initials: _____

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Parent/Guardian Authorization

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Turning Pointe Autism Foundation, its employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Turning Pointe) lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Turning Pointe Autism Foundation, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of or attempts at administration of said medication.

Parent/Guardian Signature: _____ Date: