GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Children's National Medical Center

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.

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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