Coeur d'Alene School District No. 271

STUDENTS **3510F3**

School Health Services Authorization for Medication Administration at School

Student Name: ____Date of Birth: ____________________

School: _____________________________Teacher: _______________________ School Year: _________

Medication Allergies: ____

1. Name of Medication	
2. Dose and Frequency	
3. Route	
4. Time(s) to be Administered	
5. Student may Self-Administer	Yes or No, K-5 students may self-administer only metered dose inhaler, epinephrine auto-injector or insulin and diabetic supplies.
6. Reason for Medication	
7. Medication Expiration Date	(for office-use only at drop-off)
8. Date and signature	(for office-use only at pick-up)
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3. Route	
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Additional orders: ____

Health Care Provider Signature: _______________________________________ Date: _____________

Health Care Provider Printed Name: ________________________________ Phone: _______________

Parent/Guardian Signature: ____Date: ______________

(Your signature authorizes the exchange of Private Health Information between School Health Services and your child's health care provider.)

School Nurse Signature: ____Date:_______________

PRN Medication Administration Record

Medication Name	Date	Time	Signature

Coeur d'Alene School District No. 271

STUDENTS 3510F3

STUDENT'S NAME: ____ Date of Birth: ____________________

All controlled medications **MUST** have documentation of having been counted each time a new bottle is brought in. Controlled medications must be counted by the school staff member receiving the meds and witnessed by a parent each time a controlled medication is brought in. The number of pills will be documented on this form, name of medication, number of pills, date and signature of both staff member and parent/guardian.
Controlled medications include but are not limited to: Dexedrine, adderall, cylert, ritalin, concerta, methylin, codeine, oxycontin, percocet, valium, xanax, empirin, fiorinal, tylenol with codeine, darvon, diastat, lomotil, lorcet, lortab, vicodin, norco, dilaudid, talwin.

Documentation of medication brought to school for student:

Name of Med: ______________________Amount (#): ____________ Date: _________ Staff: ___________ Parent: _________
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Name of Med: ______________________Amount (#): ____________ Date: _________ Staff: ___________ Parent: _________

Medication picked up from school by parent:

Name of Med: ______________________Amount (#): ____________ Date: _________ Staff: ___________ Parent: _________

Medication wasted/destroyed:

Name of Med: ______________________Amount (#) _____________ Date: _________ Staff: ___________Witness:_________