Hopkins Public Schools

"Committed to Quality Education for our Children's Future"

400 CLARK STREET - HOPKINS, MI 49328 - (269) 793-7261 - FAX (888) 557-7919 - www.hpsvikings.org

Authorization for Prescribed Medication or Treatment

This form must be completed fully for HPS staff to administer the specified medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication. Medication policy requirements include, but not limited to, the following:

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- An adult must bring the medication to the school.
- The school RN will call the parent/guardian and/or prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Student Demographics

This form is valid for the ______-______ school year (including summer session). Date: ___________ School: ____________________

Name of Student: ____ DOB: _______________ Teacher/Grade: ___________________

Medication Physician Authorization

Condition for which medication is being administered: ____

Name of medication: ____ Dose: __________________ Route: _________________

Time/frequency of medication (at school): ___________________________________ If as needed, frequency: ____________________

Medication shall be administered from (date): __________/_____________/___________ to __________/_____________/__________

If as needed, for what symptoms: ____

Relevant side effects: ☐ None expected ☐ Specify: ____

Form of medication: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐Injection ☐Nebulizer ☐ Topical ☐ Other: _________________

Special Storage Requirements: ☐ None ☐ Specify: ____

This student is both capable and responsible for self-administering their prescribed inhaler/epipen: ☐ Yes (Unsupervised) ☐ Yes (Supervised) No

This student may carry their prescribed inhaler/epipen: ☐ Yes ☐ No Other Considerations: ____

Have you provided additional information as an attachment (i.e. asthma/seizure/diabetes/allergy action plans, etc.): ☐ Yes ☐ No

Physician's Name/Title: ____ Office Phone: ____________________________

Office Address: ____ Fax Number: ____________________________

Physician Signature: ____ Date: __________________________

Medication Parent/Guardian Authorization

- I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA with proper medical release of information documentation.
- I request designated school personnel to administer the medication as written above. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA with proper medical release of information documentation.
- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- Our physician has instructed that this medication should be administered in the above designated dosage.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: ____ Date: ____________________

Phone Number: ______________________________ Home Cell ☐ Work