MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current)_____________including the summer session.

DEERFIELD COMMUNITY CENTER (DCC)

This form must be completed fully in order for DCC to administer the required 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

- Prescription medication must be in a container labeled by the pharmacist or prescriber
- Non-prescription medication must be in the original container with the label intact
- An adult must bring the medication to school

PRESCRIBER'S AUTHORIZATION

Name of Child:____ DOB:__________________ Grade:_______

Condition for which medication is being administered:____

Medication Name:_________________________________ Dose:____

Time/Frequency of administration: ____

If only when necessary, what symptoms:____

Relevant side effects: ___None Expected ___Specify:____

Medication shall be administered from _____________________ to ___________________________
Date Date

Prescriber's Name/Title:____

Telephone:___________________________

Address:____

____

(Use for Prescriber's Address Stamp)

Prescriber's Signature:_______________________________ Date_______________________

PARENT/GUARDIAN AUTHORIZATION

I request DCC 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 child 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 DCC staff to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:____Date:________________________

Primary Phone:____ Work Phone:__________________________________

OFFICE USE ONLY

Order reviewed by DCC Staff:____ Date___________________________