

John Glenn School Corporation

Medication Administration Authorization

Student Name: _____ School: _____

DOB: _____ Grade: _____ School Year: _____

**** This section is to be completed by the PRESCRIBING PHYSICIAN/PRACTITIONER for all prescribed/maintenance medication.****

<p>1. Medication Name: _____ Dose: _____ Route: _____ Time: _____ PRN: Yes Diagnosis/ICD-10: _____ Duration of medication: _____ If end of school year, please check box:</p> <p>2. Medication Name: _____ Dose: _____ Route: _____ Time: _____ PRN: Yes Diagnosis/ICD-10: _____ Duration of medication: _____ If end of school year, please check box:</p> <p>3. Medication Name: _____ Dose: _____ Route: _____ Time: _____ PRN: Yes Diagnosis/ICD-10: _____ Duration of medication: _____ If end of school year, please check box:</p>

Physician/Practitioner Signature: _____ Date: _____

Physician/Practitioner Name (printed): _____ NPI: _____

I give my consent for authorized and trained personnel to assist _____ in taking medication at school in compliance with JGSC policies and procedures. I understand that I am responsible for delivering all controlled substances to the school office in its original packaging with label intact. I understand all medication needs to be picked up at the end of the school year. If medication is left after the last day of school, I understand medication will be disposed of by healthcare staff. By signing this consent, I give permission to the school nurse to communicate with the supervision physician/practitioner in regards to any side effects related to this medication.

Parent/Guardian Signature: _____ Date: _____