

**Rising Tide Charter Public School**  
***Authorization for Prescription Medication Administration***

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_  
Medication Name: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

**PARENT/GUARDIAN CONSENT - please address each of the following:**

1. I request and give permission to the school nurse or trained and designated school personnel to administer this medication to my child as prescribed.  
 Yes  No
2. I give permission for my child to self-administer this medication if the school nurse determines it to be safe and appropriate. I understand that the Medication Self-Administration Plan on the back of this form needs to be completed if I select this option.  
 Yes  No
3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration as she determines necessary for my child's health and safety.  
 Yes  No
4. I understand that in the event of a field trip the medication administration plan may need to be adjusted.  
 Yes  No
5. I give permission to the school nurse or trained and designated school personnel to administer this medication to my child as prescribed during a field trip.  
 Yes  No
6. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following the termination of the order of the last day of school.  
 Yes  No

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**LICENSED PRESCRIBER**

Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Route: \_\_\_\_\_ Frequency: \_\_\_\_\_ Time of administration at school: \_\_\_\_\_

\*Whenever possible, medications should be scheduled at times other than school hours.

Adverse Effects: \_\_\_\_\_

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Effective Dates: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Consent for self-administration (provided the school nurse determines it is safe and appropriate)  YES  NO

Name of Licensed Prescriber (print): \_\_\_\_\_ Title: \_\_\_\_\_

Signature of Licensed Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**Rising Tide Charter Public School**  
***Self-Administration Prescription Medication Plan***

Please note that self-administration is usually reserved for inhalers, Epi-Pens, glucose monitoring tests, and insulin delivery systems. Once completed and signed, this form may be copied and given to the student for whom self-administration is determined to be appropriate. The original is to be retained by the school nurse in the medication book. The medication is to be entered and recorded in the computerized health record for inclusion in the medication statistics.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Medication to be taken: \_\_\_\_\_

Route: \_\_\_\_\_ Time: \_\_\_\_\_

Instructions: \_\_\_\_\_

Amount of medication to be carried by the student: \_\_\_\_\_

How will medication be carried by the student?  Backpack

Pocketbook/purse

Where will replenishing of medication be done?  In the Nurse's Office

At Home

When should the student go to the Nurse's Office?  At the end of each school day

At the end of each week

When medication orders change

If I have the following side effects/symptoms, I should go to the Nurse's Office:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Plan Discontinuation:

Reason: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Authorized by: \_\_\_\_\_

Signature: \_\_\_\_\_

**MEDICATION ADMINISTRATION PLAN (To be completed by school nurse)**

Medication: \_\_\_\_\_ Date ordered: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Time to be given: \_\_\_\_\_

IHCP: Yes/No      Refrigerate: Yes/No      Order received: Yes/No

Nurse's Signature: \_\_\_\_\_