Prairie Crossing Charter School
Student Medication Authorization Form
ONE MEDICATION PER FORM

This form must be completed fully in order for Prairie Crossing Charter School 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 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
- The school nurse or school staff will call the prescriber, as allowed by HIPPA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: ______________________________ Date of Birth: ___________________________ Grade: ______________

Condition for which the medication is being administered: ____

Medication Name: ____________________________________Dose:_____________________________ Route: ________________

Time/Frequency of administration: ____ If PRN Frequency: ___________________________

Relevant side effects: ☐ None expected or ☐ Specify: ____

Medication shall be administered from: __________________________________ to ____

Month/Day/Year Month/Day/Year

Prescriber's Name/Title (Print): _______________________________________

Telephone: ____

Address: ____

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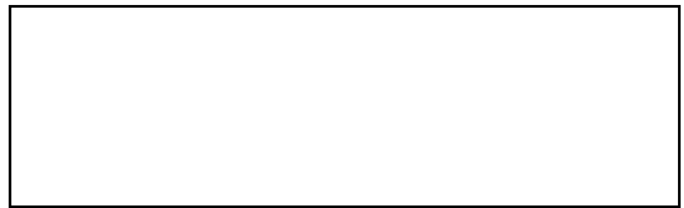

(Use for Prescriber's Address Stamp)

Prescriber's Signature: ____Date:__________

(Original signature or signature stamp only)

Parent/Guardian Authorization

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Prairie Crossing Charter School and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of Prairie Crossing Charter School), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than school nurse, and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against Prairie Crossing Charter School, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify, Prairie Crossing Charter School, its employees, and agents, either jointly or severally, from and against any and all claims, damage, causes of action or injuries incurred or resulting from the administration of said medication. I authorize the employees and agents of Prairie Crossing Charter School to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian Signature: ____ Date: ______________________________

Best Phone Number for Contact: ___________________________________

Self-Carry/Self Administration of Emergency Medication Authorization

I certify that ___________________________has been instructed in the use and self-administration of the medication described above. He/she understands the need for the medication, and necessity to report to the school personnel any unusual side effects. He/she is capable of using this medication independently.

Prescriber's Signature: ____Date:__________ Phone: ______________________

(Original signature or signature stamp only)

I give permission for my child, ___________________________________, to carry the medication described above. I will notify the school of changes in medication for my child's condition. I indemnify and hold harmless Prairie Crossing Charter School and its employees and agents against any claims, expect a claim based on willful and wanton conduct, arising out of the self-administration of medication by Student.

Parent. Guardian Signature: ____ Date: ____________________