ATTACHMENT A

BUREAU OF INDIAN EDUCATION

AUTHORIZATION TO ADMINISTER PRESCRIBED/OVER-THE-COUNTER MEDICATION

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize designated and properly instructed school personnel to administer prescribed medication as directed by the prescribing physician or other duly licensed provider (PART II below). I certify that I have legal authority to consent to the administration of prescribed medication following the provider's order. I understand additional prescriber/parent authorizations will be necessary for each medication to be administered, and if the dosage of the medication is changed. If necessary, I authorize **the designated school health care official to communicate with the prescriber or the student's health care provider as allowed by HIPAA.**

STUDENT INFORMATION

Student Name _____**Date of Birth** _____**Gender M** ___ **F** ___
Last First MI

School _____**Grade**_____**School Year**_____**Height (inches)** _____**Weight (lbs)** _____

List all medication(s) student is taking, including over-the-counter medication(s):

_____

_____

List any known drug allergies/reactions: _____

Parent/Guardian Signature _____ **Date** _____

Contact Number(s): _____ **(Day)** _____ **(Evening)**

PART II—TO BE COMPLETED BY THE PRESCRIBER

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ **Diagnosis:** _____

Dosage: _____ **Time(s)/Frequency to be given:** _____

Route of Administration: _____ **PRN (as needed)** ___**Yes** ___**No** **If PRN, (signs/symptoms):** _____

_____

Side Effects: _____

Begin Medication: _____ **Stop Medication:** _____
Date **Date**

Special Instructions:

Refrigeration required? ____Yes ___No
Is medicine a controlled substance? ____Yes ___No
Is this an emergency self carry/self administration medication? ___Yes ___No
Has student been instructed in the proper self administration of medicine? ___Yes ___No

Prescriber's authorization for self carry/self-administration of emergency medication: _____
Signature **Date**

Prescriber's Name/Title: _____ **Phone**_____
(Type or Print)

Address:_____ **Fax**_____

Prescriber's signature: _____ **Date**_____

PART III—TO BE COMPLETED BY School Nurse/Other Duly Licensed Health Care Provider

- ☐ Parts I and II above are completed, including signatures.
- ☐ Prescription medication is properly labeled by a pharmacist and within the expiration date.
- ☐ Medication label and prescriber order are consistent.
- ☐ Over-the-counter medication is in an original container with manufacturer's dosage label intact.

Principal/Authorized School Personnel Signature _____**Date**_____