HMONG AMERICAN PEACE ACADEMY

MEDICATION AUTHORIZATION

Student Name: _____ DOB: _____

Grade Level: _____

PRESCRIPTION MEDICATION(S) - *TO BE COMPLETED BY MEDICAL PRACTITIONER*

Diagnosis: _____

Medication Name	Dosage & Route	Time(s) & Frequency	Duration	Reason for Administration	Adverse Effects or Contraindications
			Start: Stop:		
			Start: Stop:		
			Start: Stop:		

Practitioner Information (Required for *all prescription* medication administered at school):

Practitioner Name: _____ Phone Number: _____

Address: _____

The prescription medication(s) listed above will need to be administered at school.

For rescue inhaler and epinephrine injection only (for students in grades 6-12 only):

- ☐ In my professional opinion, this student should be allowed to self-carry/administer this medication.
- ☐ In my professional opinion, this student should NOT self-carry/administer this medication.

Practitioner's Signature: _____ Date: _____

NONPRESCRIPTION (OVER THE COUNTER) MEDICATION(S)

Medication Name	Dosage & Route	Time(s) & Frequency	Duration	Reason for Administration
			Start: Stop:	
			Start: Stop:	
			Start: Stop:	

Parent/Legal Guardian Consent (Required for *all* medications):

I am authorizing my child, _____, to receive prescription and/or nonprescription (over the counter) medication(s) while at school at the time(s) indicated and as designated by myself and/or his/her practitioner.

I will be responsible for bringing the nonprescription (over the counter) or prescription medication(s) to school in the original labeled container from the manufacturer or pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication(s) at school to avoid any interruption in my request or the practitioner's order. Failure to do so may result in the discontinuation of the school's administered medication program for my child.

I understand that, if my child refuses to take the nonprescription (over the counter) or prescription medication(s), force will not be exerted by school personnel to make him/her comply.

I hereby authorize HAPA school personnel to communicate with the practitioner if there are questions or concerns regarding the medication(s) prescribed. I also agree to complete and sign the required disclosure paperwork at the practitioner's office to authorize the practitioner to speak with HAPA school personnel regarding the medications(s) prescribed to my child.

I accept and agree to comply with all responsibilities for administration of medication at school outlined in this document.

Parent/Legal Guardian's Signature: _____ Date: _____

Phone Number: _____

PARENT/STUDENT RESPONSIBILITIES FOR ADMINISTRATION OF MEDICATION AT SCHOOL

1. Prescription and nonprescription medication(s) will not be administered to a student by any Hmong American Peace Academy personnel unless the *Medication Authorization* form is completed, signed by the parent/guardian (and the practitioner for a prescription medication), and filed with the school nurse.

2. The *Medication Authorization* form requires:
    a. Clearly written instructions for the administration of prescription medication signed by the practitioner
        i. Name of the medication
        ii. Prescribed dosage
        iii. Frequency of administration
        iv. Conditions and/or circumstances requiring administration of the medication, when applicable
    b. Parent/guardian signed consent for all prescription and nonprescription medications

3. The *Medication Authorization* form can be obtained from the school nurse office during normal school hours.

4. The *Medication Authorization* form must be renewed each school year, unless the orders are discontinued, changed, or withdrawn in writing by the practitioner. If there is a change in the medication, the dosage amount, or the time it is to be administered, a new *Medication Authorization* form must be completed, signed by the parent/guardian and practitioner, and filed with the school nurse.

5. Parents/guardians will complete the necessary disclosure paperwork at the practitioner's office authorizing the practitioner to communicate with HAPA school personnel regarding the medication(s) listed on this form.

6. All medications must be brought to school and taken home by a parent/guardian. Medication should not be sent to school with students. Medication will not be sent home with students.

7. Prescription medication(s) must be in the original labeled container from the manufacturer or pharmacist and clearly identify the student, medication, dose, frequency, and name of the prescribing practitioner. Nonprescription (over the counter) medication(s) must be in the original labeled container from the manufacturer.

8. Students are NOT permitted to self-administer or self-carry any medication(s), except rescue inhalers and epinephrine injections as prescribed and authorized above by the practitioner. If a student self-administers a rescue inhaler or epinephrine injection, the school nurse should be notified immediately.

9. The first dose of a newly prescribed medication should not be administered at school.