

MEDICATION ADMINISTRATION FORM  
AUTHORIZATION FOR STUDENT TO SELF-MEDICATE  
Heichal Hatorah Yeshiva High School  
70 Sterling Place  
Teaneck, NJ 07666  
201-335-0633

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Date of Birth (Month/Day/Year) \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_ Preparation/Concentration: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

For additional medications, please attach schedule including names, doses, routes and times.

Choose all options that are appropriate:

- ☐ Student may carry medication & may self-administer (Parent must initial/sign below)
- ☐ Store medication in school office & student to self-administer with adult supervision (Parent must initial/sign below)
- ☐ Student to carry & self-administer on school trips and/or after school programs. (Parent must initial/sign below)

In School Instructions

- ☐ Standing daily dose: at \_\_:\_\_ AM/PM and \_\_:\_\_ AM/PM AND/OR PRN \_\_\_\_\_

Specify signs, symptoms or situations \_\_\_\_\_

- ☐ Time Interval: q \_\_ minutes or q \_\_ hours as needed ☐ If no improvement, repeat in \_\_ minutes or \_\_ hours for a maximum of \_\_ times

Conditions under which medication should not be given:

\_\_\_\_\_  
List medications taken at home: (include over the counter) \_\_\_\_\_

Healthcare Provider (please print/stamp) \_\_\_\_\_

\_\_\_\_\_  
Address Telephone \_\_\_\_\_

\_\_\_\_\_  
Healthcare Provider Signature

\_\_\_\_\_  
Date

**PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION**

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's healthcare provider. I understand that I must provide the school with the medication and equipment necessary to administer medication, i.e., nebulizers, inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter

medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I further understand that I must immediately advise the school nurse and the principal and/or his/her designee(s) of any change in the prescription of instructions stated above.

**\*\* SELF-ADMINISTRATION OF MEDICATION:** Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications.

\_\_\_\_\_ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage, and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize Heichal Hatorah, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication with the instructions of my child's healthcare provider should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition I agree to provide "back up" medication in a clearly labeled container to be kept in the event my child does not have sufficient medication to administer.

\_\_\_\_\_ I also authorize the school nurse, principal and /or his/her designee(s) to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

Parent/Guardian's Signature \_\_\_\_\_

Print Parent/Guardian's Name \_\_\_\_\_

Date \_\_\_\_\_

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