SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name _____

School _____ Grade_____ Teacher _____ School Year_____

List any known drug allergies/reactions_____Height (inches)_____ Weight (lbs)_____

PRESCRIBER AUTHORIZATION

Name of Medication_____Reason for Taking (optional)_____

Dosage _____ Route _____ Frequency/Time(s) to Be Given_____

Begin Medication_____ Stop Medication_____
Date Date

Special Instructions:

Does medication require refrigeration? Yes □ No □

Is the medication a controlled substance? Yes □ No □

Is self-medication permitted and recommended for this student? Yes □ No □

If asthma inhaler or emergency medication, do you recommend this medication be kept **"on person"** by the student? Yes □ No □

Potential Side Effects/Contraindications/Adverse Reactions_____

_____

_____

Treatment Order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary)

_____

I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication(s).

_____ _____ _____ _____

Signature of Prescriber **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the principal, his/her designee, or the school nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate. The parent/guardian shall give the first dose of new medication at home in case of a possible allergic reaction.

_____ _____ _____

Signature of Parent or Guardian **Date** **Phone**

I authorize and recommend self-medication by my child for the above medication. *I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).*

_____ _____

Signature of Parent or Guardian **Date**

If any questions or problems arise, call me at: (H)_____ (W)_____ (Cell)_____