MEDICATION AUTHORIZATION AND ADMINISTRATION 2017-2018

Parents/Guardians of students requesting that any **Prescription** or **Over The Counter** item to be administered during school hours by school staff are required to provide the school with: this form with all sections filled out as well as the medication in the original container (unopened if OTC) transported to/from the school by an adult.

NOTE: THIS FORM WILL REMAIN VALID FOR THE DURATION OF THE SCHOOL YEAR UNLESS OTHERWISE SPECIFIED

Student Name: _____ Birth Date: _____ Grade 17-18: _____

FOR PHYSICIAN TO FILL OUT

I have prescribed or authorized the following medication for this child and request that it be given during school hours.

Medication Name (*one form per order*): _____
Directions for Use/Dosage: _____
Possible Side Effects: _____
Reason for Medication: _____
Special Instructions: _____

May child self-administer this medication? ☐Yes ☐ No
Please describe: _____

If order is for an EPI pen, may the child carry with him/her? ☐Yes ☐No
If order is for an inhaler, may the child carry with him/her? ☐Yes ☐No

Physician's Name (printed): _____ Physician's Phone: _____
Physician's Signature: _____ Physician's Fax: _____
Date: _____

FOR PARENT OR GUARDIAN TO FILL OUT

Please initial that you have read and agree with the following statements

____ I request this medication be given as prescribed
____ I release the school personnel from any liability in the administration of this medication
____ I understand that I am responsible for ordering medication and an adult must bring to/from the school
____ I understand
____ I have checked that items will not expire during the school year
____ I understand I need to notify the school immediately of any medication changes
____ I understand that medications will not be administered by a school nurse as the school doesn't have a nurse on site
____ I understand that any medications will be brought on any school field trips
____ I understand that medication orders may be shared with school personnel working with my child and/or 911 personnel in the event of an emergency to promote safety for my child

I authorize my child to carry and self-administer his/her inhaler ☐Yes ☐No ☐N/A
I authorize my student to carry his/her EPI pen ☐Yes ☐No ☐N/A
I give consent for school staff to contact the above physician with any medication questions ☐Yes ☐ No

_____ _____
Parent/Guardian Signature Date

Please return to Agamim Classical Academy via email (info@agamim.org) or fax (952-856-2728)