Jane Goodall Environmental Sciences Academy #4229
2015 - 2016

SCHOOL MEDICATION PRESCRIBED/PARENT AUTHORIZATION – Part 1 of 2

STUDENT INFORMATION

Student's Name _____Date of Birth_____

School _____JGESA_____ Grade _____ School Year _____

List any known drug allergies/reactions _____Height (inches)_ _____ Weight (lbs) _____

Section A: PRESCRIBED AUTHORIZATION – ***(If more than one medication is required, continue on reverse side)***

Name of Medication _____ Reason for Taking _____

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 yes, do you recommend this medication be kept "on person" by the student? Yes ☐ No ☐

Potential Side Effects/Contradictions/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 ***(please print)***	**Date**	**Phone**	**Fax**

PARENT AUTHORIZATION

I authorize the school health professional to assist 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 health professional to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the school health professional. It must be in the original, unopened, sealed 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 expiration when appropriate.

_____	_____	_____	_____
Signature of Parent	**Date**	**Phone**	**Cell**

SELF-ADMINISTRATION AUTHORIZATION

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	**Date**	**Phone**	**Cell**

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Section A - Continued

PRESCRIBER AUTHORIZATION

Name of Medication _____ Reason for Taking _____

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 yes, do you recommend this medication be kept "on person" by the student? Yes ☐ No ☐

Potential Side Effects/Contradictions/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 ***(please print)*** **Date** **Phone** **Fax**

PRESCRIBER AUTHORIZATION

Name of Medication _____ Reason for Taking _____

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 yes, do you recommend this medication be kept "on person" by the student? Yes ☐ No ☐

Potential Side Effects/Contradictions/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 ***(please print)*** **Date** **Phone** **Fax**