CHARLES A. BEARD MEMORIAL SCHOOL CORPORATION

REQUEST AND AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

2017-2018 SCHOOL YEAR

All spaces must be complete before medication will be administered at school.

To be completed by Prescribing Health Care Provider

Upd. 4/17

Name of Student:_____________________________Date of Birth:______________Grade:__________

Address:_____________________________________Teacher:________________ BUS #____________

Medication Name:____________________________Dose:__________________Route:_____________

Condition which medication is being prescribed:____

Time of day dose is to be administered at school (Parent/guardian MUST give the morning dose at home. School personnel will not administer AM doses.):_______________________________________

If medication is to be given "as needed:, please list frequency (i.e. "every 4 hours")________________

If "as needed", please list specific symptoms requiring medication:_____________________________

Start date of medication:____________________

Stop date (dose will be given on the date specified, but not after)______________________________

Side effects:____

Prescriber's Printed Name and Title:_________________________Telephone:____________________

Address:____Fax:__________________________

Prescriber's Signature:____________________________________Date:_________________________

NOTES: Your Pharmacist can provide an extra prescription container for "school use". It is the parent's responsibility to provide safe delivery of medication and equipment to and from school and to pick up remaining medication/equipment.

TO BE COMPLETED BY PARENT/GUARDIAN

I request that school personnel administer medication as prescribed by the health care provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

I authorize the principal, health assistant and school corporation nurse to communicate with the prescribing health care provider regarding this student's medical condition.

I give permission for my student's medical information to be shared with teachers and other school personnel.

I agree to abide by the guidelines regarding medication administration at school.

Parent/Guardian's Printed Name:______________________________Cell phone __________________

Parent/Guardian's Signature:________________________________Date:_________________________