SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name _____
Date_____

School_____
Grade_____

List any known drug allergies/reactions_____ Height_____
Weight_____

PRESCRIBER INFORMATION

Name of Mediation _____ 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/Condradictions/Adverse Reactions

_____

Treatment Order in the event of an adverse reaction:

_____
(*Attach additional sheet or use the back of this form is necessary*)

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

_____ _____ _____
Signature of providor (*Please Print)* Date Phone

PARENT AUTHORIZATION

I authorize Spring Valley School personnel 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 Spring Valley School to talk with the prescriber or pharmacist should a question come up about the medication

Medication must be registered with the principal or his/her designee. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, the name of the 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