

Alden-Conger Public School
Physician Order for Prescription Medication and Parent/Guardian Authorization
Form

Prescription Medication

Student _____ Birthdate _____
Parent/Guardians _____ Grade _____

PHYSICIAN'S ORDER

I hereby request and authorize you to administer to the above named student:

	<u>MEDICATION</u>	<u>DOSAGE</u>	<u>TIME</u>	<u>DURATION</u>
1.	_____			
2.	_____			
3.	_____			

Diagnosis/medical reason for medication: _____

Other medications this student is taking: _____

Other recommendations/unusual side effects: _____

Physician's Signature _____ Date _____

Print Physician's Name _____ Ph. # _____

Clinic _____ Fax # _____

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication be given to my child during school hours as ordered by this student's physician.
2. I will immediately notify the school of any change in the medication or physician's order, dosage change, frequency, or duration of administration.
3. I give permission for authorized school personnel to communicate with other school personnel about the action and side effects of the medication.
4. I release the Alden-Conger Schools from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.
5. Field Trips: I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure. I also release all school personnel, the Alden-Conger Schools, and any responsible adult administering the medication from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

Parents Signature _____ Date _____

Alden-Conger Public School
Over-the Counter Medication Authorization Form

Student Name _____ Grade _____

For the parent:

1. Medication _____ Method of Admin: Oral/Topical

Dosage _____ Time(s) Given _____

2. Reason for medication (Diagnosis): _____

Reason for medication to be given during school hours: _____

3. I request personnel at Alden-Conger Schools to give the above named medication
to: _____

(Student Name)

4. We understand that the school is not responsible, if the child has a reaction from the medication.

5. We will provide the school with the medication in the container it was purchased in (not pill boxes, plastic bags or other containers).

6. We would like this medication-discontinued on _____ or the school will be notified of any changes.

Parent Signature _____ Date _____

Self-Administration of Medication Authorizations

Parent/Legal Guardian's Request and Authorization for Self Carry/Self-Administration

I, request and authorize my child _____ to carry and/or Self-Administer their medication _____.
(Name of Medication)

This authorization is given based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication.
- I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication and take appropriate disciplinary actions.
- I understand that this authorization shall be effective for this current school year and must be renewed annually.

Parent/Legal Guardian Signature _____ Date _____

Student Signature _____ Date _____

Physician's/Licensed Prescriber's Authorization to Self Carry/Self Administer

I, certify that _____ has a medical condition and/or
(Student's name)
potentially threatening illness _____, and this student
(Specify illness or condition)
is capable of and has been given instruction in the proper method of self-administration of

_____. Discontinuation Date _____
(Name of Medication)

_____. Date _____
Licensed Prescriber/Physician's Signature

Phone # _____ Address _____
(Licensed Prescriber/Physician's Address)

Alden-Conger Public School
MEDICATION POLICY

- 1) Since the administration of medication to students presents some potential problems, it is preferred that medications be given at times outside school hours, if possible. If not possible, trained school staff will assist students and parents with this responsibility
- 2) A Physician Order for Medication and Parent/Guardian Authorization Form must be completed before a student can be given any prescription medication during school. For prescription drugs, a doctor needs to fill out the form and sign it. Parental permission to administer the prescription medication is required also. Only the approved form will be accepted. The school will not accept permission written on other forms or papers. It is the parent's responsibility to get the permission form from the school and have it accurately completed before the medication is administered.
- 3) Some circumstances require students to carry and administer their own medications. e.g. Inhalers, Epi-pen, Glucagons. Authorization forms needs to be completed and approval will be determined on a case-by-case basis by the school administration.
- 4) Prescription medications must be in a pharmacy-labeled container that matches the physician's order(s). Over-the-counter medication must be in the container it came in when purchased.
- 5) Medications shall be given by school personnel only within these guidelines to be in compliance with the law. Absolutely no medication will be given without proper authorization.
- 6) An updated list of all students on medication within a building will be maintained in the administration's office. This list will note medication, dosage, time, purpose, and possible side effects of all medications given.
- 7) The authorization for administration of a medication will expire at the end of the current school year.