Sol Aureus College Preparatory

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Sol Aureus College Preparatory personnel to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless any of their staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided S.A.C. Prep staff are following the physician's order as written in Part II below. I assume the responsibilities as required.

Student: _____ Birthdate: _____/_____/_____ School: _____

Prescription: ☐ Renewal ☐ New If new, the first full day's dosage was given at home on: ____/____/____

List all medication(s) student is taking:

_____

_____ _____-_____-_____ ____/_____/_____
Parent/Guardian Signature *Phone Number* *Date*

PART II—TO BE COMPLETED BY THE PHYSICIAN

Sol Aureus College Preparatory discourages the administration of medication to students in school during the school day. Any necessary medication that can possibly be administered before and after school should be prescribed. Only non-parenteral medications are administered. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ Diagnosis: _____
Trade name and/or generic

Dosage: _____ Time(s) To Be Given At School: _____
Ranges not accepted (i.e. 1 to 2 tabs or 2 to 4 puffs)

Route of Administration_____ Effective Dates: ____/____/____ to ____/____/____

Side Effects: _____

If PRN, specify:

When indicated (signs/symptoms) _____

Frequency of administration _____
Ranges not accepted (i.e. every 2 to 4 hours)

_____ _____ _____-_____-____ ____/____/___
Physician's Name (print) *Physician Signature* *Phone Number* *Date*

SELF-CARRY/SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of medication such as inhalers **must** be authorized by the prescriber and be approved by the school director according to the state medication policy.

Prescriber's authorization for self-carry/self-administration of medication: _____ ____/____/____
Signature *Date*

PART III—TO BE COMPLETED BY THE PRINCIPAL

☐Parts I and II above are completed, including signatures. (It is acceptable if all items of information in Part II are written on the physician's stationery/prescription blank.)

☐Prescription medication is properly labeled by a pharmacist.

☐Medication label and physician order are consistent.

_____ ____/____/____
Director of Operations Signature *Date*