STONELEIGH-BURNHAM SCHOOL
School Medication Prescriber/Parent Authorization
Please fill out a separate sheet for each medication prescribed.

Student Name _____Date of Birth _____ School Year _____

List any known drug allergies/reactions:
_____

Medication _____

Reason for taking _____

Dose _____ Route___ _____

Frequency/Time(s) to be given _____

Begin medication _____ Stop medication _____

Special Instructions:

Does medication require refrigeration? Yes No
Is medication a controlled substance? Yes No
Is self-medication permitted / recommended? Yes No (only with approval of the Director of Health Services under the guidance of the School's medical provider)
If asthma inhaler or emergency medication, do you recommend this medication be kept "on person" by the student? Yes No

Potential side effects:
_____

Treatment order in the event of adverse reaction:
_____

_____

Signature of Prescriber _____ Date _____

Phone _____ Fax _____

Address _____

PARENT AUTHORIZATION

I authorize the Health Care Center staff to administer and to delegate to unlicensed school personnel the task of administering the above medication to my child. I understand that additional parent /prescriber signed statements will be necessary if there are changes to the above order. I also authorize the Health Care Center staff to talk with the prescriber or pharmacist should a question come up about the medication.

*Medication must be in the original container and be properly **labeled in English** with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the drug's date of expiration when appropriate.*

We have also provided an original prescription (hard copy) for this medication so that the School pharmacy can refill the medication on an as-needed basis.

Parent/Guardian Signature _____Date _____

SELF-CARRY

The **only** items that will be allowed to be self-administered are **Epipens and Inhalers**. Any other self-administration of medication(s) will have to be approved by the Director of Health Services under the guidance of the School's medical provider.

I authorize and recommend self-medication by my child for the above allowable medication(s). I also affirm that they have been instructed in the proper self-administration of the prescribed medication(s) by their medical provider. I shall indemnify and hold harmless the School and any agents of the School against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Parent/Guardian Signature _____Date _____

Home Phone _____Work _____ Cell _____