

Medication Authorization Form



2013-2014

Student's Name: _____ DOB: _____ Grade/Teacher _____

Students are not permitted to have medications in their possession while on the school campus. If medications need to be taken while at school, the student must come to the clinic to obtain it from the Nurse or other qualified person. The medication must be kept in the locked medicine area of the clinic. It is the student's responsibility to come to the clinic for the prescribed medication at the appropriate, predetermined time. With certain medical conditions, (e.g. diabetes, asthma, severe allergy) emergency medications may be kept in the classroom with the teacher. Records will be kept of all medications administered.

All prescription and over the counter medications must be in the original container and labeled by the manufacturer or pharmacist. Medications will not be given from an envelope or plastic bag. The label must include:

- *Student's Name
- *Physician's Name
- *Name of Medication
- *Exact Dosage of Medication
- *Date Prescription filled
- *Expiration Date of Medication

***Please Note:** The dosage and instructions on the Medication Authorization Form **MUST** match the information on the prescription container. A new authorization form must be received if the medication dosage is changed during the school year. When filling a prescription, ask the pharmacy for a "school bottle," and they will provide another container with the correct label. If the medication is not labeled properly, it will NOT be given.

A parent/guardian will pick up any medication that is left over in the clinic at the end of the school year. If the medication is not picked up on or before the last day of school, it will be discarded.

Authorization and Consent to Administer Medications and Medical Treatment

I authorize Mount Paran Christian School, through its Nurse or other qualified person, to administer first aid or other minor medical treatment as shall be deemed best under the circumstances to my child. I consent for my child to receive such treatment during school hours and at school activities, including all school sponsored programs. I understand the school will attempt to notify parents/emergency contact in the event of an emergency requiring immediate medical care for my child. If the school is unable to notify me, I give permission for my child to be treated by a fully qualified physician at the nearest emergency clinic. I release the Board of Directors, school and any school employee from liability for administering medications and first aid to my child. I agree to hold harmless, indemnify the school, its employees and agents either jointly or severally, from and against any and all claims, damages, causes of action or injuries that arise from the medicating of my child while at school or at school-sponsored events. I acknowledge that it is my responsibility to keep my child's records (phone numbers, work location, emergency contact, health status, and immunization records) current. I also understand that neither medical nor accident insurance is provided by Mount Paran Christian and that the responsibility for providing such coverage rests with me as parent/guardian for my child.

The Nurse or other qualified person at Mount Paran Christian School has my permission to administer the following medication to my child, _____, as prescribed by Dr. _____, for the purpose of treating _____.

I give permission for the Nurse to contact the physician, if necessary.

Name of Medication: _____

Dose to be given: _____

Time to be given: _____

Physician's phone #: _____ Prescription # _____

Signature of Parent/Guardian

Date