BRIDGE Elementary

AUTHORIZATION FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION FORM*

Name of Student:_____ DOB:_____

Address:_____ Home Phone:_____

Parent/Guardian:_____ Cell Phone:_____
Work Phone:_____

Emergency Contact:_____ Phone:_____

Name of licensed health care provider completing form:_____

Licensed Health Care Provider's Statement:

1. Name/type of prescribed medication:_____

2. Method for administering medication:_____

3. Dosage/amount to be given:_____

4. Frequency/times to be administered:_____

5. Duration (week, month, indefinite, etc.):_____

6. Anticipated reactions to medication (symptoms, side effects for under dose/overdose, etc.):

_____

7. Administration of the prescribed medication described above by school employees during periods when the student is under the control of the school is medically necessary.

_____ _____

Signature of Licensed Health Care Provider *Date*

Parent/Guardian Request and Approval:

I hereby request and give my permission for my student named above to receive the specified prescribed medication as stated in the above instruction from the health care provider. I understand that school administration will designate specific staff to administer the medication during regular school hours, train staff, assure proper identification and safekeeping of the medication, and maintain records of such administration of medication.

I further understand that school personnel who provide assistance in the administration of the specified prescribed medication in substantial compliance with the health care provider's written prescription and the employers of such personnel are not liable, civilly or criminally, for any adverse reaction suffered by my student as a result of taking the medication or discontinuing the administration of the medication in keeping with the procedure outlined above.

_____ _____

Signature of Parent/Guardian *Date*

***This form does not apply to administering glucagon, seizure rescue medication, epinephrine, or an opiate antagonist.**