Royalton Public Schools Medication Authorization Form 1A

Parents of pupils requesting that prescription medication be administered during school hours by school staff are required to provide for the school:

1. The physician's order
2. A parental release, and
3. Medication supplied in the original container.

Ask for prescription medication to be divided in two bottles completely labeled-one for home and one for school.

Students Name_____DOB_____
Grade_____Teacher_____School_____

PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I have prescribed the following medication for this student and request the dosages given during the school hours.
Medication name:_____Dose:_____Frequency:_____
Route: _____Time:_____PRN Repeat Frequency_____

- *Morning medication dose_____mg. to be given at school, **only** if student forgets to take at home.*

For treatment of:_____Possible side effects_____
Medication Allergies:_____Any other medications taken at this time_____
Please check the box(s) below if applies:

- ○ Student may self administer his/her inhaler.
- ○ Student may self administer his/her EPI-pen injector.
- ○ Student may self administer his/her insulin-pen.
- ○ Student needs this medication while on field trips.
- ○ Student may carry his/her inhaler
- ○ Student may carry his/her EPI-pen
- ○ Student may carry his/her insulin-pen

Any Special Instructions_____
Order Expires:_____

Physician's Signature_____Date_____Phone_____

Print Physician's Name_____

Parental Request for Administration of Medication

I request this medication be given as prescribed and I give the Health Services Staff to communicate with the ordering physician about this medication. I release the school personnel from any liability in the administration of this medication at school. I give permission to the school nurse to communicate with the student's teachers about my student's health condition and the action of the medication and/or treatments or procedures as deemed medically necessary. ***I understand that medication will not necessarily be administered by a school nurse.**

Parent/Guardian Signature_____
Daytime Phone:_____Date_____