AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

(For use **only if student needs a prescription medication during the school day** 2018-2019)

Instructions: Each of the three sections must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian, Part II by Physician. Please return the completed form to the School Health Office.
Suzy Fischer ECA Fax #: 305-935-5331

I. STUDENT INFORMATION (To Be Completed By Parent/Guardian)

Name of Student: ____ DOB: _________ Grade: _____

Allergies: ______________________ Parent/Guardian: ____

Cell Phone: ____________________ Work Phone: ___________________ Other Phone: ______________

II. ACTION PLAN (To Be Completed By Physician). Please complete all spaces.

Diagnosis: ____ Height: _________ Weight: ___________

Start Date of Medication: _________ Stop Date of Medication: _________ Continue Entire School Year: _____

Medication: ____________________________________ Generic Name (If Used): _____________________

Dosage Amount: ________________________________ Time To Be Administered At School: ____________

Side Effects: ____

Student Capable and Responsible to Self Medicate: ☐ No ☐ Yes - Supervised ☐ Yes - Unsupervised
(Insulin, Inhaler or Epi pen only)

Purpose of Medication: ____

Physician Signature: _______________________________________ Date: __________________________

Physician Name (please print): _______________________________ Phone Number: __________________

Physician Address: ____

III. PARENTAL PERMISSION (to be completed by parent or guardian)

Permission is hereby granted to the School Nurse or designated school personnel to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of Suzy Fischer Early Childhood Academy, its personnel, or agents for civil damages as a result of the administration of this medication to my child; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container (please ask pharmacy for separate labeled bottle for school); (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and Suzy Fischer Early Childhood Academy health personnel.

Parent/Guardian Signature: ____ Date: ____________________

Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication, or any change in medication requires a new form. The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired.