Hebron Academy

PRESCRIPTION MEDICATIONS

Student's Name: _____

Medication	Dosage	Time of Day Taken	Reason for taking	Prescribing Physician

Please include your ***home pharmacy***:
Name_____Address_____
Phone_____Fax_____

Medication Contract

I agree to report to the Student Health Center for daily medication administration. If I am not in compliance with this contract, then my parents or guardian will be notified.
When the Health Center is closed or my child is off campus for a school activity, I understand that my child's medication will be given by the dorm faculty, teacher or coach responsible for my child at that time.

By my signature below, I consent to the dispensing and delivery of the prescribed medication by Bedard pharmacy to Hebron Academy Student Health Center. I also release the pharmacy and agents from all liability, including acts of omission or commission resulting or arising from receipt of the prescribed medication. I understand that:

- I authorize the pharmacy to bill my insurance provider for services
- I understand a copy of my medical records will be stored in a confidential manner
- I authorize Hebron Academy Student Health Services to receive, administer and educate my child on the prescribed medication and the potential side effects of the medication.
- Hebron Academy Student Health Services will alert the prescriber and pharmacist of any adverse reactions or medical conditions arising from the prescribed medication.
- Should a change in any of the above occur, I understand that a revised, written physician's statement and parent authorization must be submitted.

Student's Signature_____Date_____

Parent or Guardian's Signature_____Date_____

Physician's Signature_____Date_____