CHARLES A. BEARD MEMORIAL SCHOOL CORPORATION

REQUEST AND AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

2022-2023 SCHOOL YEAR

All spaces must be complete before medication will be administered at school. *Updated 6/20

TO BE COMPLETED BY PRESCRIBING HEALTH CARE PROVIDER

STUDENTS NAME: _____GRADE/TEACHER: _____

ADDRESS: _____ BUS #_____

MEDICATION: _____DOSAGE/ROUTE: _____

TIME TO BE GIVEN AT SCHOOL: _____HOW MANY: _____

PARENT/GUARDIAN MUST GIVE THE MORNING DOSE AT HOME. SCHOOL PERSONNEL WILL NOT ADMINISTER AM DOSES*

QUANITY OF MEDICATION SENT TO SCHOOL (number of tablets in bottle):_____

CONDITION WHICH MEDICATION IS BEING PRESCRIBED: _____

START DATE OF MEDICATION: _____STOP DATE OF MEDICATION: _____

IF MEDICATION IS "AS NEEDED", PLEASE LIST SPECIFIC SYMPTOMS REQUIRING MEDICATION: _____

SIDE EFFECTS TO MEDICATION: _____

PRESCRIBER'S PRINTED NAME/TITLE: _____TELEPHONE:_____

ADDRESS: _____FAX:_____

PRESCRIBER'S SIGNATURE: _____ DATE: _____

NOTES: Your Pharmacist can provide an extra prescription container for "school use". It is the parent's responsibility to provide safe delivery of medication and equipment to and from school and to pick up remaining medication/equipment.

TO BE COMPLETED BY PARENT/GUARDIAN

I request that school personnel administer medication as prescribed by the health care provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

I authorize the principal, health assistant and school corporation nurse to communicate with the prescribing health care provider regarding this student's medical condition.

I give permission for my student's medical information to be shared with teachers and other school personnel.

I agree to abide by the guidelines regarding medication administration at school.

PARENT/GUARDIAN'S PRINTED NAME: _____HOME/CELL: _____

PARENT/GUARDIAN'S SIGNATURE: _____ DATE: _____

___SCANNED TO STAFF	**____ACKNOWLEDGEMENT FORM TO STAFF**
___IN INOW	**____ON MEDICAL CONFIDENTIAL LIST**