# BRIARWOOD CHRISTIAN SCHOOL

## SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

This authorization is given by the parent(s)/Guardian of the below named student to Briarwood Christian School, a ministry of Briarwood Presbyterian Church ("School") in consideration of School accepting student to School.

### STUDENT INFORMATION

**Student's (Child's) Name** _____ **Date of Birth** _____

**Grade** _____**Teacher** _____ **School Year** _____ **Height (inches)** _____ **Weight (lbs)** _____

**List any known drug allergies/reactions** _____

### PRESCRIBER AUTHORIZATION MEDICATION

**(*Please Print All Information*) Name of Medication** _____ **Reason for Taking** _____

**Dosage** _____ **Route** _____ **Frequency/Time(s) to be given** _____

**Begin Medication (Date)** _____ **Stop Medication (Date)** _____

**Name of Doctor and Doctor's Authorized Agent (if any) (Print)** _____

**Special Instructions:**
Does medication require refrigeration? Yes ___ No ___
Is the medication a controlled substance? Yes ___ No ___
Is the medication premeasured? Yes ___ No ___
Is self-medication permitted and recommended for this student? Yes ___ No ___
If yes, do you recommend this medication be kept "on person" by the student? Yes ___ No ___

**Potential Side Effects/Contraindications/Adverse Reactions** _____

**Treatment Order in the event of an adverse reaction** _____

**Other Instructions** _____
*(If more space is necessary to answer any of the above, attach additional sheet or use the back of this form.)*

**I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication(s).**

_____ _____ _____ _____
**Signature of Doctor or Doctor's Authorized Agent** **Date** **Phone** **Facsimile**

### PARENT AUTHORIZATION

I authorize the School to delegate to unlicensed school personnel the task of giving to or assisting my child in taking the above medication. I understand that additional parent/medical signed statements will be necessary if the dosage of medication is changed. I authorize any representative of the school to talk with the physician, his agent, or pharmacist should a question come up about the medication.

Medication must be registered with the principal or his/her designee. It must be up to date at all times, in the original sealed container and be properly labeled with the student's name, physician's name, date of prescription, name of medication, dosage, strength, time interval, and route of administration.

_____ _____ _____ _____
**Signature of Parent** **Date** **Phone** **Cell**

**Print Name:** _____

### SELF-ADMINISTRATION AUTHORIZATION

I authorize and request self-administration by my child for the above medication. I also affirm that my child has been instructed in the proper possession and self-administration of the prescribed medication by his/her attending physician. I have determined and assume the responsibility that my child is able and qualified to self-administer his/her medication. I hereby certify that I am informed that School, its employees and any agents have immunity by law from any liability for any injury or claim that may arise related to my child having possession of or using the self-administered medication. I agree to indemnity and hold harmless the school, its employees and agents against any claims that may arise by child or any other person relating to the possession, use and/or self-administration of medications by my child or anyone (including payment of all medical and legal costs including attorney fees). This authorization shall expire at the end of the current academic year, but the indemnification shall be continuing.

_____ _____ _____ _____
**Signature of Parent or Guardian** **Date** **Phone** **Cell**

**Print Name:** _____