Prescription Medication Disclosure and Authorization Form

Student Name:_____ **DOB**:_____

Please list **all** of your child's prescription medications, and any other regularly administered medications that may affect your child while at School. Please identify any medication which must be administered at School, including prior to or during sports or other school-sponsored activities. Use additional pages if needed.

Medication #1: _____
Dosage and Route: _____
Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ends:_____
Administered at School?
Significant Information (possible side effects/adverse reactions):

Medication #2: _____
Dosage and Route: _____
Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ends:_____
Administered at School?
Significant Information (possible side effects/adverse reactions):

Medication #3: _____
Dosage and Route: _____
Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ends:_____
Administered at School?
Significant Information (possible side effects/adverse reactions):

This medication order is valid for one year from the date of signing.
I request that the medications noted on this form be given to this student during school hours and at school-sponsored events. I understand that only the school nurse, appointed school personnel, or a designated adult/volunteer chaperone may administer medication unless the "Self-Carry and Self-Administration Authorization" section of this form is complete. In that case, the parent/guardian and student have determined that the student can safely self-administer medication during overnight trips. The school shall incur no liability as a result of any conditions from the medication; I shall hold harmless the school, its employees, or agents against any claims arising from the administration of medication to this student.

Optional: Self-Carry and Self-Administration Authorization (For Overnight Trips – Middle School and Upper School Students Only):
Please complete if your MS/US student will carry and/or self-administer medication during school-sponsored overnight trips.

Parent/Guardian Acknowledgment:
[ ] I agree to allow my child to bear the responsibility of carrying the medications listed above
[ ] I agree to allow my child to bear the responsibility of self-administering the medications listed above
[ ] My child is able to demonstrate proper use and care of the medications listed above.

Student Acknowledgment:
[ ] I plan to keep the medications above with me during overnight trips
[ ] I will use these medications in a responsible manner, as directed by my healthcare provider.
[ ] I will notify school staff if I have difficulty managing my medication or the condition I use it for.
[ ] I will not share these medications with others.
Student Signature: _____ **Date**: _____

Physician, CRNP or PA Signature: _____ **Phone:** _____
Printed name of **physician, CRNP or PA**: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date**:_____

*Must be signed by a **healthcare provider** that is licensed to prescribe medications and actually prescribes the medications identified to the student, and **parent/guardian**.*