

Stone Bridge School

ADMINISTRATION OF MEDICATION

Student's **physician/health care provider** **MUST** complete this form for **all prescription** that require administration to a student during school hours

Name of Student: _____ Birthdate: _____ Grade: _____

Medication (In original bottle only. Use separate sheets for multiple medication): _____

Dosage, time and method of administration (Dosage may not exceed recommendation on the bottle):

Describe symptoms/ triggers (If allergic in nature, please specify what type of reaction, i.e., localized, generalized, mild, severe):

Possible reactions that need to be reported to the student's physician/health care provider:

Disposition of student following administration of medication (i.e. rest in office, send home, return to class, etc.):

The above medication cannot be scheduled for other than during school hours and such medication maybe administered by medically un-trained school personnel whenever necessary.

For Asthma Medication only:

Is student capable of self-administering? _____ Student may/should carry medication: _____

Physician/Health Care Provider Name: _____ Phone: _____

Address: _____

Date of Authorization: _____ Continue medication to date: _____

Authorization Signature of Physician/Health Care Provider _____

Prescription Medication Will Not Be Given Without Physician's /Health Care Provider's Authorization!

I request that my child (named above) be assisted in taking the above named medication at school by school personnel (or by an adult designated by the class teacher during a field trip) and will comply with the policy and procedures of the school. I give consent for the school nurse/ authorized school personnel to communicate with the physician/health care provider and to counsel with school personnel regarding the above named student and medication as appropriate. I understand the school is not legally obligated to administer medication to any student and therefore agree to hold the school and district harmless from any liability resulting from the administration of the above named medication.

Parent Authorization Signature: _____ Date: _____

Home Phone#: _____ Work Phone #: _____