Administration of Prescription Medication Form

Student's name _____ Birth date _____

To be completed by the student's provider (Physician/Nurse Practitioner/Dentist)

Name of medication _____ Dosage _____

Frequency/Time _____ How administered _____ Date to begin _____

Permission for this medication is only valid through the end of the current school year unless otherwise noted. EXCEPTION: For emergency medications for asthma, anaphylaxis, seizure, or diabetes, this permission can be valid for 3 years. A provider order is required for any changes in this medication.

Date to terminate emergency medication _____ (3 years)

Please attach an emergency action plan with procedures to be followed if emergency medication does not alleviate student's emergency.

For Epinephrine orders only: ____ I have determined that this student is capable of possessing and using this auto injector/epipen appropriately and have provided the student with training in the proper use of the auto-injector.

Severe reactions that should be reported to the physician: _____

_____

Special conditions for storage of drug: _____

Provider's signature _____ **Date** _____

Provider's name _____ **Emergency phone #** _____

To be completed by the student's parent

The medicine must be in pill, capsule, liquid, auto-injector, or inhaler form, and must be clearly marked from the pharmacist. The label must show the student's name, medication name, dosage directions, prescribing doctor, and prescription number.

Pharmacy name _____ Phone number _____

As the parent or guardian of this student, I give permission for a designee of The Ethel Streit School to administer the prescribed medication. I agree not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agree to hold harmless from any liability incurred as a result of the administration or non-administration of any medicines. I will inform the school if there is a change in any of this information.

____ As the parent/guardian, I authorize the student to possess and use an **asthma inhaler** as prescribed, at the school and any activity, event or program sponsored by or in which the school participates.

____ As the parent/guardian, I authorize the student to possess and use an Epinephrine Auto-Injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the school participates. I understand that a school representative will immediately request assistance from an emergency medical service provider if this medication is administered. **I will provide a backup dose of the medication to the school as required by law.**

Name of parent/guardian _____

Signature of parent/guardian _____ Date _____

Primary emergency phone _____ **Secondary emergency phone** _____