Authorization of School Personnel to Administer Medications

****ONLY ONE MEDICATION PER FORM****

Name of Student:______________________________ Birth Date:________________
Address:____
Home Phone: ____________________ Other Phone: ____________________
Parent/Guardian:______________________________ Phone:________________
Emergency Contact:(other than parents):______________________ Phone:______________
Name of licensed health care provider completing form (*please print*):

____

Licensed Health Care Provider's Statement:

1. Name/type of medication:______________________________
2. Dosage/amount to be given:______________________________
3. Frequency/times to be administered:______________________________
4. Duration:______________________________
5. Anticipated reactions to medication (symptoms, side effects for under dose /overdose, etc.):

____

______________________________ ________________
Signature of Licensed Health Care Provider *Date*

Parent/Guardian Request/Approval

I hereby request and give my permission for the above named student to receive the specified medication as stated in the above instruction from the health care provider. I understand that the school administration will designate specific staff to administer medication, train staff, assure proper identification and safekeeping of medication, and maintain records of such administration of medication. I further understand that school personnel who provide assistance (administration of specified medication so noted) or employer of such staff are not liable, civilly or criminally, for any adverse reaction suffered by my child as a result of taking the medication so indicated and discontinuing the administration of the medication in keeping with the procedure outlined above. I agree to bring the medication to school in a container from a pharmacist, properly labeled including name of student, doctor, date, dosage, name of medication and method of administration. I also agree to notify the school of any change or discontinuation of the medication. I will personally deliver medication to the school and understand that a one-week supply is recommended.

______________________________ ________________
Signature of Parent/Guardian Date

Self Administration Release Statement

1. Name/type of medication:______________________________
2. Dosage/amount to be taken:______________________________
3. Frequency/times to be taken:______________________________
4. Duration:______________________________
5. Anticipated reactions to medication (symptoms, side effects for under dose /overdose, etc.):

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______________________________ ______________________________
Signature of Administration Date Signature of Parent/Guardian Date

(*Summit Academy Use Only*)

Disposal of Medication

Notification Date: ____________________ Staff Signature: ____________________
Two Weeks Disposal Date: ________________ Staff Signature: ____________________
Method of Disposal: ____________________ Witness Signature: ____________________