

Physician's authorization for long term medication

Name of medication to be given for 2 weeks or longer: _____

This student is allowed to self-administer this medication while at school and understands the implications of doing so. He/she has demonstrated competency in self-administration of this medication. The parents are aware that they cannot hold Bethlehem Christian Academy responsible for any adverse outcome of this action.

This student does need assistance in the school clinic by the designated personnel in administering this medication

Plan of Action:

If you see these symptoms: Follow these actions:

Any additional information from the Physician regarding this child and medication:

I have seen this child and agree with all the information provided on this authorization form.

Physician's Signature

Date

Office address

Office phone

Bethlehem Christian Academy Medication Authorization Form

Student's Name _____ Birth Date _____
School _____ School Year _____
Grade _____ Teacher _____

Please initial that you have read and agree to the following:

- ___ All medications whether *prescription* or *over-the-counter* must be in the **original labeled container** (NO baggies or foil).
- ___ A parental note cannot override the labeled directions for prescription or over-the-counter medication.
- ___ Parental/guardian must provide specific instructions, as well as the medication and related equipment to the Administrator or Clinic Personnel.
- ___ It is the responsibility of the parent/guardian to inform the school of any changes. If there is a change in prescription doses either a new labeled container or a signed note from the prescribing physician must be provided.
- ___ All medication will be taken directly to the office/clinic **by the parent**
- ___ Unused medication will be disposed of unless picked up within one week after medication is discontinued.
- ___ It is the responsibility of the parent/guardian to ensure that all of the medication in the container arrives to school.

List all medications to be given at school:

1. _____ prescription? Y N Dosage and time to be given: _____
Pills in Container: _____ Start Rx on: _____ Stop Rx on: _____ Contact Parent before administering? Y / N
Possible adverse reaction to watch for and describe what actions should be taken? _____
2. _____ prescription? Y N Dosage and time to be given: _____
Pills in Container: _____ Start Rx on: _____ Stop Rx on: _____ Contact Parent before administering? Y / N
Possible adverse reaction to watch for and describe what actions should be taken? _____
3. _____ prescription? Y N Dosage and time to be given: _____
Pills in Container: _____ Start Rx on: _____ Stop Rx on: _____ Contact Parent before administering? Y / N

(Note if different from labeled directions the school will not give the medication)

Not to exceed 2 weeks without a physician's statement/signature on back of this form

I hereby request that Bethlehem Christian Academy, through the Administrator or designee, supervise/assist in the administration of medication to my child, named above, and according to the instructions contained in the statements above. I release the Board of Directors, Bethlehem Christian Academy and any school employee from any liability for administering this medication. This permission must be renewed annually for medications that are needed on a continuous

Parent/Guardian Signature

Date

Parent/Guardian home#

work#

cell #