Notre École

FRENCH IMMERSION STEAM SCHOOL

Medication Authorization Form

Student Name: ______________________________ DOB: _______________ Grade: ______________

Parents/Guardians asking school staff to give medications to their child must provide written permission **each school year that has been signed by both the parent/guardian and a licensed heath care provider,** including over-the-counter medications, herbals, and supplements.

****Any student with a health condition that could result in an emergency: asthma, seizures, severe allergies, etc., must also submit an emergency action plan provided by their clinic****

Directions: Please fill out one form per medication. All medications must be supplied to the school's office in the original container with the pharmacy label and transported by an adult. **Medications without completed authorization forms cannot be given.**

Physician/Licensed Prescriber Section

I have prescribed and authorized the following medication to be administered by the appropriate trained school personnel:

Medication: ________________________________

Dose/Route: ________________________________

Frequency:_________________________________

Reason for medication: ______________________

____

Special Instructions: _______________________

____

Please check for emergency medications only (epinephrine injectors, inhalers, etc.):

- ❏ After discussion with parent/guardian, I deem this student capable of self-carry and I have explained instructions to the student.
- ❏ After discussion with parent/guardian, this student will **NOT** self-carry their medication.

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Physician Name (printed)

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Physician Signature

____

Clinic Name

____

Phone Number Fax

Parent/Guardian Authorization

1. I request that the medication be given as ordered during school hours/field trips by school personnel.
2. I will notify the school of any change in the medication and will provide new medication before current medication is expired (expired medication cannot be given).
3. I give permission to both the school and health care provider listed to consult about any questions regarding the medication or health conditions being treated by the medication.
4. I understand that all medication (except emergency medication) must be kept in the office for the safety of all students.
5. **Please check for emergency medications only (epinephrine injectors, inhalers, etc.)**, after discussion with the health care provider, I agree that my child:
   - ❏ May **not** self-carry.
   - ❏ **May self-carry and self-administer.**
   - ❏ **May self-carry, but needs assistance to administer.**
6. **I accept all responsibility in the even that the self-carry medication is lost or misused.**
7. **I release school personnel from any liability in the administration of this medication.**

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Parent/Guardian Signature Date

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Name (printed) Phone Number