Yav Pem Suab Academy

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Scholar: ______________________________ Age: ________ Birthdate: ________________

School: Yav Pem Suab Academy ______________________________ Grade: ________

PLEASE NOTE: this form must be completed each school year or more frequently, if necessary.

Medication may be dispensed to scholars at school if the following information is completed and the parent/guardian agrees to the following terms and conditions. This form is valid for one (1) school year.

TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

TO PHYSICIAN: Please note: Medical personnel are not available on the school campus. Whenever possible, please prescribe medication that can be given outside of the school day. If medication must be administered during school hours, please complete the information below:

MEDICATION: ______________________________

DOSAGE AND ROUTE: ______________________________

TIME(S) TO BE DISPENSED AT SCHOOL: ______________________________

REASON FOR MEDICATION: ______________________________

DURATION: ______________________________

SPECIAL INSTRUCTIONS/PRECAUTIONS: ______________________________

POSSIBLE SIDE EFFECTS: ______________________________

a. For emergency medication, is the scholar capable of self-administering the necessary treatment/medication?
   ☐ Yes ☐ No
b. Will the scholar need to carry this medication on his/her person? ☐ Yes ☐ No
c. Will the scholar need to self-administer this medication? ☐ Yes ☐ No

Physician's printed name and signature:

**Physician's License #: ______________________________ Date: ________________

Address: ______________________________ Phone Number: ________________

Physician's Signature: ______________________________

**Nurse Practitioners and Physician Assistants: please provide furnishing # and information of supervising physician.

Parent Request

Please check one of these boxes.

☐ I/We the undersigned, the parent(s) of ______________________________ request that medicine be administered by a designated member of the school staff, in accordance with the instructions outlined here and signed by our physician. The medication is to be given at ____________ (time) with the following special instructions: ______________________

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In agreeing to have the school administer our son's/daughter's medication, I understand the following: A school nurse is not available to give medication and a staff member may be assigned to assist. Medication must be labeled by a pharmacist and in the pharmaceutical container. The label must state the scholars name, date of birth, name of medication, dosage, time(s) to be given, special instructions and the physician's name. Over-the-counter medication must remain in the original container and be labeled with the scholar's name. I hereby give consent to exchange of information regarding this medication between ______________________________ , and the pharmacist and/or physician. ______________________________

☐ As indicated in our physician's statement, our child, ______________________________ will self-administer his/her own medication when required and we are not requesting school personnel to assist in the administration of our child's medication. Our child will need to self-administer his/her medication at school because he/she suffers from ____________________ ____ (state nature of illness)

____

Parent/Guardian Signature Date Home Phone Work Phone

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Address

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Emergency Contact Phone