CONGRESSIONAL SCHOOL

MEDICATION AUTHORIZATION

Student Name:_____ Date of Birth:_____ Grade:_____

This form permits Congressional School's ("the School") designated healthcare providers to administer prescription, over the counter (OTC), and emergency medication to a student while at school and School-related events, and outlines expectations for parents/guardians surrounding medication administration. This Medication Authorization ("Form") must be completed for each medication a student requires by the student's parent/guardians. The Licensed Prescriber Authorization section should be completed by the student's licensed prescriber for each medication a student requires for longer than ten (10) school days.

I, the parent or legal guardian of the above-identified student (the "Student") permit the School's designated healthcare providers to administer medication as noted below.

Name of Medication: _____

Reason for Medication:_____

Dose:_____ Route:_____

Frequency:_____

Duration of Treatment(s):_____

Special Instructions:_____

The Student has the following known food, drug, or other allergies: _____

_____

I further agree and understand as follows:

1. It is my sole duty to ensure that the Student has an adequate supply of all medication during the course of the school year and to communicate any and all changes in medication(s), dosage(s), or concerns relating to side effect(s) with the School Nurse.

2. Prescription medication must be in the original container with pharmacy label attached, or in the original packaging if OTC.

3. The Student's name must be included on the original container of the prescription or OTC medication.

4. Emergency medications require an action plan completed by the Student's licensed prescriber.

5. Short term OTC medications and antibiotics only require a parent/guardian signature on this Form, and may be kept in the School clinic for ten (10) school days only.

6. Medication will only be administered to the name on the label and in accordance with prescribed instructions.

7. Prescription orders and action plans expire at the end of each school year. New prescription orders and actions plans must be submitted each school year.

8. The Student may not carry medication during the school day, unless the Student is authorized to self-administer the medication by the School and the Student's licensed prescriber.

In consideration of the School administering medications to the Student, I, on my own behalf and on behalf of the Student, forever release, acquit, discharge, covenant to hold harmless, and covenant not to sue the School, its trustees, employees, representatives, agents, and volunteers (collectively the "Releasees") from any and all claims, suits, liabilities, actions and causes of action, including, but not limited to, negligence (but not gross negligence) of the Releasees, which I or the Student or our heirs, legal representatives, successors, conservators and assigns may have, now or in the future, which arise directly or indirectly out of the administering or assistance in administering of medications to the Student.

I have read this Form in its entirety and understand what it means. I affirm that I have legal custody of the Student and that I am authorized to sign on the Student's behalf. By signing below, I acknowledge and agree that the electronic signatures below have the same legal effect and validity as a written signature, and that this form is valid and will be given the same legal effect as a written and signed form.

Signature Of Parent/Guardian #1:_____ Date:_____

Print Full Name Of Parent/Guardian #1:_____

Parent/Guardian Emergency Phone Number: _____

Signature Of Parent/Guardian #2: _____ Date:_____

Print Full Name Of Parent/Guardian #2:_____

LICENSED PRESCRIBER AUTHORIZATION

(To be completed by a licensed prescriber for prescription medication and over the counter medication for longer than ten school days)

Student Name: _____ Date of Birth: _____

Medication: _____ Date of Prescription: _____

Diagnosis/Reason for Medication (unless confidential): _____

Dates medication must be administered at the School:
_____Short Term (List dates to be given _____)
_____Every day at school
_____Episodic/Emergency Events ONLY

Dosage (Amount) _____ Route _____ Form _____ Time(s) of Day _____

Frequency:_____

Duration of Treatment:_____

Special Instructions:_____

A. Serious reactions can occur if the medication is not given as prescribed: __ YES __ NO

If yes, describe: _____

B. Serious reactions/adverse side effects from this medication may occur: __ YES __ NO

If yes, describe: _____

Action/Treatment for reactions/adverse side effects: _____

Report to you: __ YES __ NO (Drug information sheet may be attached.)

Special Handling Instructions: ___ Refrigeration ___ Keep out of sunlight
___ Other (describe _____

Please complete for asthmatic/diabetic students <u>ONLY</u>

This Student is both capable and responsible for self-administering this medication:
__ NO __ YES - Supervised __ YES - Unsupervised

This Student may carry this medication: __ NO __ YES

Licensed Prescriber's Name: _____

Telephone Number: _____Emergency Number: _____

Licensed Prescriber's Signature: _____ Date: _____