ADMINISTRATION OF PRESCRIPTION MEDICATION AND/DR MEDICAL TREATMENT FORM

Student Information

Student's Name: _____ Grade/Class: _____

(If applicable) Student's Health Care Number. _____ Student's Date of Birth: _____

Home Address: _____

Contact Information

Mother's Name: _____ Father's Name: _____
Work Phone: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Cell Phone _____

Emergency Contact Name: _____ Phone: _____
Physician's Name: _____ Phone: _____

Severe Allergy Alert Information

This portion of the form *should be completed only* /If/he *student* has a severe *allergy. A* severe *allergy is defined as* a severe *allergic reaction or anaphylactic response which, If left untreated, can lead to sudden death*

Allergen(s): _____

Symptoms of a reaction: _____

Emergency Action Plan (*attach separate sheet needed)*

_____

_____

_____

_____

Medication/Treatment Information

Medication prescribed: _____

Purpose of medication: _____

Medication dosage, time of administration and procedure for administration: _____

Medication storage and safekeeping requirements: _____

Specifies of treatment required, ifany: _____

Medication/Treatment Information {CONT}

Possible side effects of medication/treatment and remedial action for side effects: _____

_____

Will it be detrimental to the student's health if a single dose/treatment is omitted? Yes— No—

Must this student have this medication/treatment administered during school hours in order to be able

To attend school? Yes— No—

Self-Administration Information

Is this student able to administer his/'her own medication/treatment? Yes— No—

If yes, provide details: _____

_____

Informed Parental Consent and Acknowledgement

I am the parent of the student named above ("my child"} and I acknowledge and agree:

1. I will provide an adequate and fresh supply of medication for my child.
2. I understand the medication will be stored in a secure location and administered by school staff unless I have given consent for my child to sell-administer the medication.
3. I understand it is my responsibility to advise school staff of any change in my child's medical condition or medication.
4. I acknowledge that actions taken by school personnel will be limited to what is possible in a school setting, and to what can be done by persons untrained in medical procedures.
5. If any emergency arises, I authorize school personnel to administer medication and/or secure medical advice and services, including calling paramedics as deemed necessary. I agree to be financially responsible for such emergency medical assistance.
6. By signing this form, I consent to and authorize school personnel to administer medication/medical treatment to my child.
7. I understand that the school fully accepts responsibility for students under its care, and is liable to the parents and the students for any loss, injury or damages which occur as a result of the negligence of the school. I am fully aware that there are risks and hazards associated with the administration of medication or medical treatment and that my child may suffer bodily injury as a result of these risks and hazards, and my child may suffer personal and potentially serious injury due to an unforeseeable or fortuitous event.
8. This form is valid only for the school year in which it is submitted.

Date:_____Name of Parent:_____ Signature_____

Physician's Endorsement

1. The information provided on this form is accurate and complete.
2. The assistance of school personnel required to administer this medication and for medical treatment is within the competence of persons untrained in medical procedures.

Date:_____Name of Physician:_____ Signature_____