ST. MARTIN'S IN-THE-FIELD EPISCOPAL SCHOOL

PRESCRIPTION MEDICATION AUTHORIZATION FORM

One form per medication per school year

MUST BE COMPLETED AND SIGNED BY A PHYSICIAN

Student Name: ________________________________ DOB:_____/______/________ Grade:_____________ School year:_____________________

Reason for Medication: ______________________________ Name of Medication: ______________________________ Dose:________________(mg,ml,ml/tsp,# of puffs)

Time of administration at school:_________________ ☐ Lunchtime Route: ________________ Effective dates: ☐ Entire school year **OR** Begin (date) __________ to terminate (date):_________

Checking here indicates the medication is an Epi-pen, inhaler, or insulin that the student can carry and self-administer: ________

Possible adverse effects: ______________________________ Possible drug interactions: ______________________________

Additional instructions: ______________________________ Student allergies: ______________________________

Physician / Prescriber Name (printed): ______________________________ Date: __________________ Physician phone: ______________________________

Physician / Prescriber signature ______________________________ The first dose of this medication (except Epi-Pen) has been given without problems: ________________
(Physician or Parent initials)

This request must be signed by a parent or guardian and the health care provider to authorize giving prescription medication during school hours.

Prescription medication must be delivered to the school nurse or nurse delegate *by an adult* in a container properly sealed and labeled by the physician or pharmacist. Container must be properly labeled with: *name of child, name of medication , dosage, route and time of administration, name of physician, prescription date and expiration date, and conditions for proper storage*. Pharmacists will provide a second labeled container if requested. The physician will be called if any questions arise about student's medication.

Having read the above conditions, I request St. Martin's in-the-Field Episcopal School personnel administer the medication as prescribed by the physician above. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Signature of Parent / Guardian: ______________________________ Date: _____________ Relationship to student: __________________________

Phone number: (H) ____________________________ (W) ________________________ Other: ___________________________

Address: ____

Below line is for school use only - must be initialed by authorized personnel each time medication is administered.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Codes:(* must document on chart)

A = Absent	**DW** = Dose Withheld*	**H** = Holiday	**Su** = Supply Depleted*
DC = Discontinued	**ED** = Early Dismissal	**NS** = No Show	**W** = Wasted*
DO = Delayed Opening	**FT** = Field Trip	**R** = Refused	**X** = Weekend

School Nurse / Delegate Signature: ______________________________ Initials: ________

Signature of persons authorized to render service:

______________________________ Initials: ________

______________________________ Initials: ________

______________________________ Initials: ________

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