MOVEMENT SCHOOL

MEDICATION AUTHORIZATION FORM

Name of Student: _____ **Student D.O.B.:** _____

School: _____ **Teacher:** _____ **Grade:** _____

In order to help protect your child's health, your consent and written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

Parent or Guardian's Permission: I give permission for my child to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve Movement School Board and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

Parent/Guardian: _____ **Phone Number:** _____ **Date:** _____

☐ This medication is to be used for emergencies only. Please allow this student to self-administer this medication

***** BOTH SIDES OF THIS FORM ARE REQUIRED FOR EMERGENCY SELF-CARRY MEDICATIONS *****

Name of Student: _____ Date of Birth: _____

Medication: _____ Strength/Dosage: _____

Medical Diagnosis: _____

How often and/or at what time (hour): _____

SPECIFIC DIRECTIONS

Purpose of medication: _____

Relationship to Meals (if applicable): _____

Expected side effects or adverse reactions: _____

Specific indications: _____

Other information: _____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

_____ _____

Please print practitioner's last name Practice name /address

_____ _____ _____ _____

Signature of Healthcare Provider Date Telephone Fax

FOR SCHOOL USE ONLY:

Date Received/By: _____ School Health Nurse Review: _____

Location of Medicine: ☐ On student ☐ Emergency medication only In Health room ☐ In Classroom

AUTHORIZATION FOR EMERGENCY MEDICATIONS SELF-CARRY BY MOVEMENT SCHOOL STUDENTS

Name of Student: _____ **Student DOB: _____**

Medication: _____ **for: _____**

Eligibility: Only students with asthma, diabetes and/or severe allergies who may require rescue medications (i.e., inhaler, glucagon, insulin, epi-pen, Benadryl).

Healthcare Provider: This student is capable of and has been instructed on how to self-carry and, if applicable, administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please allow him/her to self-carry it during school hours or activities. In the event of an emergency, this student may need assistance by a school staff member in the administration of this medication.

Healthcare Provider Signature: _____ Date: _____

Parent/Guardian: I give consent to Movement School to allow my child to self- carry and, when applicable, to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I will provide backup medication to be kept at school. I absolve Movement School and their agents and employees from any and all liability whatsoever that may result from my child carrying this medicine at school.

Parent/Guardian Signature: _____ Date: _____

Student: I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when medication is used.

Student Signature: _____ Date: _____

School Health Nurse: I have reviewed this request and agree that this student should be capable of safely self-carrying and, when applicable, self-administering this medication.

School Health Nurse Signature: _____ Date: _____