RSU #16
AUTHORIZATION FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

A physician's prescription must accompany all prescription and non-prescription over-the-counter (OTC) medication, with the exception of Tylenol. The prescription order/label must include:

- ☒ student's name,
- ☒ name of the medication,
- ☒ dosage, the route and time intervals of administration of the medication,
- ☒ potential side effects, and specific instructions or procedures for administration must also be included.

Due to possible serious adverse reactions, we ask that you give the first dose of a new prescription medication at home. All medications must be in the original bottle, and brought to and from school by a parent or designated adult**.**

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Student's Name ________________________________ DOB ___________
RT Advisor/HR Teacher______________________________ Grade ___________
Name of medication______________________________ Start date:____________
Reason for medication ___________________________ Stop date:____________
Dosage ____________________ Time of administration _______________
Prescribing physician ____________________________
Physician's ph. # ____________________ Physician's Fax. # ______________

I understand that school employees are not medically trained personnel and that the school nurse may not always be available to dispense medication. With full knowledge of this, I hereby give permission for the administration of the medication specified above by the school nurse, or by non-medical school personnel designated by the school principal. The physician prescribing this medication may be contacted in the event that complications arise or clarifying information is needed.

Parent/Legal Guardian Signature______________________________ Date __________

TO BE COMPLETED BY PHYSICIAN

I understand that school employees are not medically trained and that the school nurse may not always be available to give medication. However, in my professional opinion, the above named student needs the particular medication during school hours to maintain his/her physical, emotional, or academic well-being.

- ☒ Prescribed medication: ____
- ☒ Reason for medication: ____
- ☒ Other medications this child takes (please list): ____________________________
- ☒ Does this medication give cause to any adverse reactions when administered with other medications this child is taking? Yes / No If yes, please describe:

  ____
- ☒ Child's allergies: ____
- ☒ In the event of side effects to the medication, what action should school staff take?

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Physician's name (please print):_________________________________
Physicians Signature________________________________ Date _________

Upon request, physician's offices will fax a written prescription to Attn: School Nurse,
***PRHS/BMWMS** fax # 998-5060 **PCS** fax # 998-4998/998-8013 **ESS** fax # 346-6224*
***MCS** fax # 345-9535*

Revised 3/2010