ROCKBRIDGE
ACADEMY

Permission to Administer PRESCRIPTION Medication

Student Last Name_____ Student First Name_____ DOB_____ Grade_____
Allergies_____ Weight_____

Diagnosis:_____

_____

Name of Medication:_____

_____

Dosage:_____

Route:_____

Time to Administer:_____

Note:_____

If PRN, what symptoms:_____

_____

_____

How often: _____

Services: Begin_____ End_____

☐ Beginning to end of school year ____

PHYSICIAN

☐ **INHALER** ☐ **EPINEPHRINE AUTO-INJECTOR**
☐ **INSULIN** ☐ **OTHER**

It has been determined that:

Student is able to self carry: Y/N

Student is able to self administer: Y/N

Student has been trained in its use, including knowing when the medication is to be used: Y/N

Comments/known side effects/precautions:

_____

_____

_____

_____

Physician's Signature :_____
Physcian's Name Printed:_____
Today's Date:_____ Phone:_____
Address/Office stamp:

_____

_____

HEALTH ROOM USE ONLY

Form RECEIVED date_____ By(signature)_____

Form REVIEWED date_____ By(signature)_____

PARENT

- ✓ All prescription medication will have a physician's signed order fully completed for each school year.
- ✓ The prescription medication will be in a container labeled by the pharmacist or physician with: name of child, name of medication, dosage, route, time of administration, physician, prescription date and expiration date, and conditions for proper storage.
- ✓ The prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- ✓ The medication will be brought to school by an adult.
- ✓ The physician will be called if a question arises about my child's medication.
- ✓ The first dose of this medication (except Epinephrine auto injector) has been given without any negative side effects.
- ✓ You agree on behalf of yourself and your child/ward to indemnify and hold harmless RA, its employees and servants for any claim for damages, compensation, or other wise and to reimburse or make good any loss or damages on costs that they may have to pay if any litigation arises on account of any claims made by said minor or anyone on his/her behalf.
- ✓ I agree that my child is able to self administer and carry the inhaler/epi pen and has been trained in its use. Y/N

Having read the above conditions, I request that the RA health aide administer the medication to my child or ward. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Parent/Guardian Signature:_____
Relationship to Student:_____
Phone:_____ Email:_____