BETH TORAH
SCHECK FAMILY
RELIGIOUS SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

(For use **only if student needs a prescription medication during the school day**)

Instructions: Each of the three sections must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian, Part II by Physician. Please return the completed form to the School Health Office.

I. STUDENT INFORMATION (To Be Completed By Parent/Guardian)

Name of Student: _____ DOB: _____ Grade: _____

Allergies: _____ Parent/Guardian: _____

Cell Phone: _____ Work Phone: _____ Other Phone: _____

II. ACTION PLAN (To Be Completed By Physician). Please complete all spaces.

Diagnosis: _____ Height: _____ Weight: _____

Start Date of Medication: _____ Stop Date of Medication: _____ Continue Entire School Year: _____

Medication: _____ Generic Name (If Used): _____

Dosage Amount: _____ Time To Be Administered At School: _____

Side Effects: _____

Student Capable and Responsible to Self Medicate: ☐ No ☐ Yes - Supervised ☐ Yes - Unsupervised
(Insulin, Inhaler or Epi pen only)

Purpose of Medication: _____

Physician Signature: _____ Date: _____

Physician Name (please print): _____ Phone Number: _____

Physician Address: _____

III. PARENTAL PERMISSION (to be completed by parent or guardian)

Permission is hereby granted to the School Nurse or designated school personnel to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of Scheck Family Religious School, its personnel, or agents for civil damages as a result of the administration of this medication to my child; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container (please ask pharmacy for separate labeled bottle for school); (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and Scheck Family Religious School health personnel.

Parent/Guardian Signature: _____ Date: _____

Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication, or any change in medication requires a new form. The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired.