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RisingGround.org

The Biondi School

MEDICATION ADMINISTRATION FORM: PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

Student's Name: _____ DOB: _____

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

_____ **I understand that no student will be allowed to carry or self-administer medication.**
Initial

_____ **I understand that this Authorization is only valid for the current school year.**
Initial

_____ I authorize the school nurse to store and/or administer all physicians prescribed medication to my child.
Initial

_____ I **DO NOT** authorize the school nurse to store and / or administer all physician prescribed medications to my child. Therefore, I understand my child will not receive medication in school.
Initial

Please Print:
Parent/Guardian's Name: _____
Address: _____
_____
Day-time Telephone No. _____
Home Telephone No. _____

Parent/Guardian's Signature: _____

Date Signed _____