Trinity Presbyterian School
Medication Authorization Form

School Year: _____-_____

STUDENT INFORMATION

Student Last Name: _____ Student First Name: _____

Date of Birth: _____/_____/_____ Age: _____ Grade: _____ Homeroom Teacher: _____

List any known drug allergies/reactions: _____

OVER-THE-COUNTER MEDICATION AUTHORIZATION
(To be completed by Parent)

Medication Name: _____ Dosage: _____

Frequency/Time to be given: _____ Reason for Taking: _____

PRESCRIPTION MEDICATION AUTHORIZATION
(To be completed by Licensed Healthcare Provider)

Medication Name: _____ Dosage: _____

Frequency/Time to be given: _____ Reason for Taking: _____

Potential Side Effects or Adverse Reactions: _____

Treatment Order in event of adverse reaction: _____

Name of Licensed Health Care Provider (print) _____ Phone number: _____

Is this medication a controlled substance? Yes_____ No _____
Is self-medication permitted and recommended for this student? Yes_____ No_____
Do you recommend this medication be kept "on person" by the student? Yes_____ No_____
**If "yes", I hereby affirm this student has been instructed on proper self-administration of the prescribed medication.*

Signature of Licensed Healthcare Provider: _____ Date: _____

*****Please complete the Parent Authorization on on the second page of this form.*****

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PARENT AUTHORIZATION

I authorize the appropriate school personnel to administer the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if medication or dosing is changed. I authorize any representative of Trinity Presbyterian School to talk with the physician or pharmacist should a question come up about the medication.

Medication must be registered and kept in the appropriate school office. It must be in the original package labeled with the child's name, prescriber's name, time intervals, date, dosing, and name of medication, when appropriate.

_____ _____ _____

Signature of Parent | Date | Phone

Print Name: _____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-administration by licensed healthcare provider.)

I authorize and request self-administration by my child for the above medication. I also affirm that my child has been instructed on proper self-administration of the prescribed medication by his/her licensed healthcare provider. I certify that I am informed that Trinity Presbyterian School, its employees, and any agents of the school have immunity by law from any liability for any injury or claim that may arise related to my child having possession of or using the self-administered medication. I agree to indemnity and hold harmless the school, its employees, and any agents against any claims that may arise relating to the possession, use and/or self-administration of medications by my child or anyone (including payment of all medical and legal costs including attorney fees). This authorization shall expire at the end of this school year, but the indemnification shall continue.

_____ _____ _____

Signature of Parent | Date | Phone

Print Name: _____