BROWNE
EXCELLENCE DIVERSITY CHARACTER COMMUNITY
ACADEMY

MEDICATION AUTHORIZATION

This authorization form must be complete whenever medication is requested to be given to a student during school hours by the school nurse or school appointed designee in order to maintain sufficient health to remain in school. **Medication must not be expired and be packaged in the original, properly labeled pharmacy container. Medication in plastic bags or other non-original containers is not acceptable. Expired medication will not be accepted at school.** It is the parent/guardian's responsibility to provide and ensure medication that is to be handed in to school is not expired, will last the entire school year, or renew the medication within 10 working days. It is the parent/guardian's responsibility that the adjoining care/action plan is up-to-date with any medical changes reported to the school nurse, if applicable. Any changes in the original medication authorization requires a new written authorization and a corresponding change in the prescription label.

I hereby request designated school personnel to administer the following medications as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them in helping this student use medication, provided the designated school personnel comply with the licensed healthcare provider or parent/guardian orders set forth in accordance below.

The entire form must be completed. Omission of any part of this form will render the authorization invalid.

PART I

Student name (print) _____ DOB _____ Current grade level _____

Medication name _____ Expiration date _____ Date prescription written _____

Time to be given _____ Duration of treatment _____ Dosage _____

Diagnosis or reason medication is needed _____

Possible side effects _____ Possible serious reactions _____

Additional information (special handling instructions) _____

Adjoining care/action plan submitted to school, if applicable? (i.e., food allergy care plan, seizure care plan) ▢ YES ▢ NO

PART II Required physician authorization: student self-carry prescription EpiPen or inhaler while at school

I give my permission and consent for the child to self-carry and self-administer their prescription inhaler or auto-injectable epinephrine. I understand that the school or its employees cannot be held responsible for negative outcomes from self-administration of the prescription medications. A new care plan and treatment authorization signed by the student's physician must be submitted each school year. I understand that the child's healthcare provider must authorize the child to self-carry and administer medication while at school.

Physician authorization: the student can self-carry and self administer the emergency prescription medication while at school? ▢ YES ▢ NO

PART III All information required

Parent/Guardian name (print) _____ Signature _____

Parent/Guardian telephone _____ Date _____

Healthcare provider name (print) _____ Signature _____

Healthcare provider telephone _____ Date _____