



## MEDICATION AUTHORIZATION FORM FOR MEDICATION DURING SCHOOLDAY/DAY TRIP/OVERNIGHT TRIP

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Diagnosis \_\_\_\_\_ Allergies \_\_\_\_\_

Entire school year \_\_\_\_\_ OR From the dates: \_\_\_/\_\_\_/20\_\_\_ to \_\_\_/\_\_\_/20\_\_\_

**Inhaler:** He /she will carry the Inhaler for independent self-administration.  YES  NO

**Epipen:** He /she will carry the EpiPen for independent self-administration.  YES  NO

**Insulin:** He /she will carry the Insulin for independent self-administration.  YES  NO

### DAILY/PRN MEDICATION – PHYSICIAN AUTHORIZATION

Medication Name/Dose	Breakfast	Lunch	Afternoon	Dinner	Evening
	(please circle time of administration)				
1.	B	L	A	D	E
2.	B	L	A	D	E
3.	B	L	A	D	E
4.	B	L	A	D	E
5.	B	L	A	D	E
6.	B	L	A	D	E

\_\_\_\_\_  
Physician/CRNP/PA/Dentist SIGNATURE

\_\_\_\_\_  
NAME (Print)

\_\_\_\_\_  
DATE

**PARENT/ GUARDIAN:** All prescription and over-the-counter medications must be accompanied by a written physician order and parent/guardian permission. The physician signature on this form can be omitted if the physician noted the medication instructions on the Current School Year Physical. Prescription and over-the-counter medications must be in dosage envelopes (available from the school office), packaged, labeled, and sealed by a parent. A new form is required for each new school year and for any changes in information.

### PARENT/GUARDIAN AUTHORIZATION:

I request that my child take the medication in school as directed by the physician on this form or by the student’s yearly physical. It is the student’s responsibility to come to the health office to receive medication. I release and indemnify the Jack M. Barrack Hebrew Academy (“School”), its officers, agents and employees from any and all liability resulting from medication administration. I also authorize, as needed, the sharing of information related to my child’s health between the school nurse (or designee), the health care provider and appropriate staff during the school year in question. If at any time the student shows signs of irresponsible behavior or if there is a safety risk, the principal has the right to confiscate medication and withdraw the privilege to self-administer. The Administration will notify the parent immediately in writing.

I acknowledge that the school has no responsibility for ensuring that self-administered medications are taken. I understand that I have the responsibility to contact the school immediately if there are any changes in the student’s medical condition/medications.

Please note, the School Nurse does not attend every School Trip.

\_\_\_\_\_  
Parent/Guardian SIGNATURE

\_\_\_\_\_  
NAME (Print)

\_\_\_\_\_  
DATE