Boyne Falls Public School: ***Prescription*** Medication Authorization

Revised: 03-01-2024

The following information is required for administration of PRESCRIBED medications in school. *This form is valid for one school year.*

Student Full Name:_____Date:_____

School Year**:**_____ Grade:_____Date of Birth:_____Student Age:_____

Allergies:_____

Medical history:_____

Medication Information

Name of Medication:_____

Purpose of Medication: _____

Dosage:_____

Frequency:_____

Time(s) of Administration: _____

Beginning Date:_____ Ending Date: _____

If the above medication is an inhaler or epi pen can the student self carry? _____Yes _____No

Notes About Medication (adverse reactions, precautions, etc.): _____

_____

*SIGNATURE of Physician:*_____ *Date:* _____

PRINTED name of Physician: _____ *Date:*_____

Parent/ Guardian, please read and initial the following statements below signifying that you agree:

_____I will assume responsibility for safe delivery of the medication to school. Students must not transport medication for safety reasons.

_____I will notify the school immediately if there is any change in the use of the medication.

_____I am requesting my child be administered this prescribed medication at school by school personnel per the directions above.

_____I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian initial:_____ Date: _____ Parent/Guardian daytime phone:_____

Parent/Guardian Signature: _____