Monroe Academy

School Medication Prescriber/Parent Authorization

Student Information

Student's Name: ______________________________ Date of Birth: _____________

Grade: ______________ Age: _______________

☐ No known drug allergies

☐ Known drug allergies: List- ____

Prescriber Authorization

To be completed by licensed healthcare provider

Medication Name: _______________________________ Dosage: __________ Route: ________

Frequency/Time(s) to be given: _____________________ Start: __________ Stop: __________

Reason for taking medicine: ____

Potential side effect/ reactions: ____

Treatment order in the event of an adverse reaction: ____

Is the medication a controlled substance? ____

Is self-medication permitted and recommended? ____

If yes, has the student been instructed on proper self-administration of the prescribed medication?

☐ Yes ☐ No

Do you recommend this medication to be kept "on person" by the student? ______________________

Printed Name of Licensed Healthcare Provider: ____

Signature of Licensed Healthcare Provider: ____

Phone: _______________________________ **Fax:** ___________________________________

Parent Authorization

I authorize the office staff or Headmaster to administer or assist my child in taking the above medication. I understand that additional prescriber/parent signed statements will be necessary if the dosage of medication is changed. I also authorize the office staff or Headmaster to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with the office staff. Prescription medications must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of the drug's expiration when appropriate.

Over the Counter Medication must be registered with the office staff in the original, unopened and sealed container.

Parent's/Guardian's Signature: _____________________ Date: ______________ Phone: ___________

Self-Administration Authorization

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

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the school staff, and the board of directors against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Parent's/Guardian's Signature: _____________________ Date: ______________ Phone: ___________