Alabama School of Mathematics and Science

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name_____ Date of Birth_____

School: Alabama School of Mathematics and Science Grade _____ School Year _____

Drug Allergies/Reactions _____ Height _____ Weight _____

PRESCRIBER AUTHORIZATION (DOCTOR TO COMPLETE THIS BOX)

Name of Medication _____ Reason for Taking _____

Dosage _____ Route _____ Frequency/Time(s) to be given _____

Begin Medication Date _____ Stop Medication Date _____

Special Instructions
Does medication require refrigeration? Yes / No
Is this medication a controlled substance? Yes / No
Is self-medication permitted and recommended for this student? Yes / No
If Yes, do you recommend this medication be kept "on person"' by student? Yes / No

Potential Side Effects/Contraindications/Adverse Reactions _____

Treatment Order in the event of an adverse reaction _____

I hereby affirm that this student has been instructed in the proper self-administration of this medication(s).

_____	_____	_____	_____	_____
Signature of Prescriber	Print Prescriber Name	Date	Phone	Fax

PARENT AUTHORIZATION

I authorize the School Nurse and/or other trained school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question arise about the medication.

Medication must be registered with the president, his/her designee, or the school nurse. It must be in the original unopened, sealed container and properly labeled with the student's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate. I authorize my son/daughter to sign in and out his/her prescription medication with the nurse's office.

_____	_____	_____	_____
Signature of Parent	Date	Phone	Cell

SELF-ADMINISTRATION AUTHORIZATION

I authorize and recommend self-administration 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 agents of the school, and the State of Alabama against any claims that may arise relating to my child's self-administration of prescribed medication(s).

_____	_____	_____	_____
Signature of Parent	Date	Phone	Cell