PRINCETON REGIONAL SCHOOLS

ADMINISTRATION OF MEDICATION

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any ***prescribed or over-the-counter*** *medication to a student. Please complete this form and return to the school office.*

Name of Student _____ DOB _____ Grade _____ Homeroom _____

Address _____ Telephone (home/work/cell) _____

Allergies _____

To be completed by LICENSED PRESCRIBER

Condition for which medication is administered _____

Name of medication: _____ dosage: _____ frequency: _____ route: _____

Time or indication for administration _____

Specific instructions for administration and/or storage requirements _____

Possible side effects to be noted/reported _____

Effective Date(s) _____ Expiration date of this request _____

For ASTHMA INHALERS, EPI-PENS, INSULIN PUMPS – In my opinion, this student shows the ability to be responsible for carrying and self-administering the above medication and has received adequate instruction in use thereof. _____YES _____NO
Instructions to follow in the event medication does not produce expected relief: _____

_____

Licensed Prescriber Signature **Date**

Prescriber Name _____
(Please Print)
Address _____

Phone Number _____

To be completed by PARENT/GUARDIAN

NOTE: NO EMPLOYEE WHO IS AUTHORIZED BY A BOARD OF EDUCATION TO ADMINISTER A PRESCRIBED MEDICATION AND WHO HAS A COPY OF THE MOST RECENT PRESCRIBER'S STATEMENT WOULD BE LIABLE IN CIVIL DAMAGES FOR ADMINISTERING OR FAILING TO ADMINISTER THE DRUG UNLESS HE/SHE ACTED IN A MANNER THAT WOULD CONSTITUTE "GROSS NEGLIGENCE OR WANTON OR RECKLESS MISCONDUCT."

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:

1. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs or if the medication has been discontinued.
2. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
3. Cooperate with school personnel in assisting my child comply with medication administration instructions.
4. All medications must come to school in the original container from the pharmacist.

_____ _____ _____

Parent/Guardian Signature Date Contact Phone Number(s) – home/work/cell

I hereby authorize the building nurse to share necessary medication information about my child with the appropriate school staff. This information will be shared in a confidential manner. This authorization is valid for the current school year only. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act.

_____ _____ _____

Parent/Guardian Signature Date Contact Phone Number(s) – home/work/cell

FOR INHALERS, EPI-PENS, AND INSULIN PUMPS: It is my opinion that my child understands the use of this medication, demonstrates proper administration and has shown responsible behavior when it comes to carrying this medication. I further understand that my child will demonstrate proper administration and sign a contract stating he/she will be responsible for the medication during school. _____ Yes _____ No _____ Initials

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The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature _____ Date _____ Signature _____ Date _____
Signature _____ Date _____ Signature _____ Date _____
Signature _____ Date _____ Signature _____ Date _____
Signature _____ Date _____ Signature _____ Date _____