PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

To request that Beltsville Adventist School administer medication to your child at school, this form must be completed in full.

PARENT'S PERMISSION FOR MEDICATION AT SCHOOL

I request the student named below to be given medication at Beltsville Adventist School and school activities by qualified staff according to the prescription or nonprescription instructions and a record maintained. The student has experienced **no** previous side effects from the medication.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

✍ Parent of Guardian _____ Date _____

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL

Name of Student _____ DOB____/____/____

Diagnosis_____

Name of Medication_____

Dosage_____ (mg, ml, ml/tsp, # of puffs)

Route_____ Time of Administration at School_____

If PRN, for what symptoms?_____ How Often?_____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

_____

Services should begin (Date)_____ and terminate (Date)_____

~~FOR INHALER AND EPI-PEN MEDICATION ONLY:~~

____ It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use including knowing when the medication is to be used.

____ This student should not self-administer inhalant medication or Epi-pen.

✍ Physician's Signature_____ Physician's Name (printed)_____

Address _____

Telephone Number_____ Date_____