PRESCRIPTION MEDICATION AUTHORIZATION

[Please type or print legibly.]

This form MUST be completed and signed by **both** the physician and the parent/guardian before any prescribed medication will be administered by authorized school personnel.

Medications is to be in the original pharmacy container appropriately labeled by the pharmacy with prescriber name, name of medication, the dosage and time to be administered. The prescription bottle and physician's order MUST match

PART A. TO BE COMPLETED BY THE PHYSICIAN

1. Camper name ____ Grade ___________
2. Camper address ____
3. **Diagnosis** ____
4. Prescribed Medication ____

INHALER/EPI-PEN: As the prescriber, I have determined that this student is capable of possessing and using the said medication appropriately

and have provide the student with training in the proper use of the inhaler/autoinjector.(INHALER: __ YES __NO) (EPI-PEN: __ YES __NO) Dosage: ____

Time: ____

Begin: ____

End: ____

5. Possible adverse reactions, which should be reported: _________________________________
6. Special instructions for administration: ____

____

7. Physician's name ____

Address____

Phone number____

8. Physician's signature ____ Date ____________

PART B. TO BE COMPLETED BY PARENT/GUARDIAN

I, the __ _______________________ of __________________________________ request that the
[relationship] [camper's name]
prescribed medication listed in PART A of this form be administered to my child according to the physician's instructions. I agree to deliver the medication to the school nurse in the container in which it was dispensed by the prescribing physician or pharmacist. I also agree to notify the school nurse in writing if the medication, dosage, or any other information provided by the physician is changed or eliminated. I also release Laurel School, and any or all of the school's officers or employees from any liability or damages resulting from the consequences or adverse reaction of our child's taking or failing to take this medication at the times prescribed. I have had the opportunity to ask questions. They have fully answered to my satisfaction.

INHALER: As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed at her school and any activity, event, program sponsored by or in which the student's school participates. ___ YES ___ NO ___ NA
EPI-PEN: As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed , at he school and any activity, event, program sponsored by or in which the student's school participates. I understand that a school employee will immediately request assistance from an emergency medical service provided if this medication is administered. I I will provide a backup dose of the medication to the school as required by law. ___ YES ___ NO ___ NA

Parent Signature ____ Date_____________________

Scan & email completed forms to: summer@laurelschool.org

OR

Fax completed forms to: 216-464-8996 **/** Attention: Summer at Laurel

For additional assistance, please call 216-455-3065