THE PALOMA SCHOOL

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PHYSICIAN'S PRESCRIPTION AUTHORIZATION

Parents have the primary responsibility for the health of their child. Whenever possible, medications should be taken at home. However, if students must receive medication during the school day, the following will apply:

1) Parents and the child's physician will be required to complete this form.
2) Designated school personnel will dispense medication according to the physician's written orders.
3) All medication must be labeled correctly. The label must include name of student, drug, dosage, frequency and time of administration, pharmacy's name and address, the date and the prescription number. This is also required for inhalers. Labeled medication is stored in a secure place for the period indicated on the physician's order.
4) Parents are responsible to ensure that needed prescription refills are supplied to School.
5) At the end of the school year the parent is expected to pick up unused medication. Medication not picked up by a parent will be destroyed.
6) The preferred method of delivery to the school is by the parent. If that is not possible, medication must be sent in a sealed envelope labeled with the child's name and the amount of medication sent. Medication must be brought to the School Office immediately upon arrival at school.

TO BE COMPLETED BY THE PARENT

Child's Name: _____ Birth Date: _____

I request that the medication for my child be stored or administered as indicated in the Physician's order below. I am aware that non-medical personnel may be administering this medication to my child. I hereby release The Paloma School and all its employees from any and all liability in law for damages either we or our child may suffer as a result of this request.

Parent's Signature: _____ Date: _____

Home #: _____ Cell #: _____ Work #: _____

TO BE COMPLETED BY THE PHYSICIAN

It is necessary that the named child receive the following medication at the times as directed. Please store and administer the medication according to the following instructions:

Name and form of the medication: _____

Dosage: _____ Times to be given: _____ Duration: _____

Other specific directions: _____

Purpose of medication and/or diagnosis: _____

Other medications prescribed by the physician that the student is taking outside of school hours:

_____

Common side effects and contraindications: _____

Curtailment of specific school activity (sports, etc.): _____

_____

Print Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____