Bella Mente Academies

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

2021/2022 school year

Student:_____ Birthdate:_____ Grade: _____

Effective Date:_____

PLEASE NOTE: This form must be completed each school year or more frequently, if necessary. Prior to medication administration at school, this form must be completed and signed by a licensed health care provider AND by parent/guardian. This form is valid for one (1) school year and for one (1) medication.

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER- Please note that medical personnel are not available on the school campus. When possible, please prescribe medication that can be given outside of the school day. If medication must be administered during school hours, please complete the information below. Only one medication may be listed per form.

MEDICATION:_____

DOSAGE AND ROUTE: _____ Frequency_____

TIME(S) TO BE DISPENSED AT SCHOOL: _____

REASON FOR MEDICATION: _____

SPECIAL INSTRUCTIONS/PRECAUTIONS: _____

CONTROLLED SUBSTANCE? Yes No

POSSIBLE SIDE EFFECTS: _____

DOES THE STUDENT HAVE ANY ALLERGIES? Yes No

If "yes", please list allergen(s) and reaction history: _____

SELF-ADMINISTRATION

A. Is the student authorized to self-carry this medication? ☐Yes ☐No
B. Is the student authorized to self-administer this medication? ☐Yes ☐No

**Physician Name and License #: _____ Date: _____

Address: _____ Phone: _____

Licensed Healthcare Provider's Signature: _____

**Nurse Practitioners/Physician Assistants: Please provide the furnishing # and information of supervising physician

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TO BE COMPLETED BY PARENT/GUARDIAN

Please check only ONE of the following:

☐ I, the undersigned, the parent/guardian of:_____ (*Student's Name*), authorize that the medication may be administered by a designated member of the school staff, in accordance with the physician's signed instructions.

In agreeing to having a trained member of the school personnel administer my child's medication, I understand and agree to the following:

1. A school nurse is not available to administer medication and a staff member may be assigned to assist.
2. Medication must be labeled by a pharmacist and kept in its original pharmaceutical container. The label must state the following: student's name, date of birth, medication name, dosage, time(s) to be given, special instructions, and the physician's name.
3. Over-the-counter medication must remain its original container and be labeled with the student's name, date of birth, and medication expiration date.

☐ I, the undersigned, the parent/guardian of:_____ (*Student's Name*), authorize my child to self-administer his/her own medication, as indicated in the physician's statement above. I am not requesting school personnel to assist in the administration of our child's medication.

Parent/Guardian Name: _____ Phone #: _____

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Address: _____

Emergency Contact Name: _____ Phone #: _____

*Please Note: For any changes/updates to your child's medication(s), a new authorization form must be completed and submitted to the school. This form is only valid for one (1) school year and for one (1) medication.