MOUNTAIN BROOK CITY SCHOOLS
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
School Year: 2023-24

STUDENT INFORMATION

Student's Name: _____ **School: MOUNTAIN BROOK HIGH SCHOOL**

Date of Birth: _____/_____/_____ Age: _____ Grade: _____ Teacher: _____

(No known drug allergies---if drug allergies list: _____ Weight: _____pounds

OVER THE COUNTER PRESCRIBER AUTHORIZATION

Medication Name: _____ **Dosage: per label** **Route: per label**

Frequency/Time(s) to be given: as needed per label **Start Date: ____/___/____ Stop Date: ____/___/____**

PHYSICIAN ORDER REQUIRED by LEA: YES ____ NO____ **(all orders good for one calendar year less otherwise noted)**

Reason for taking medication: see label
Potential side effects/contraindications/adverse reactions: see label
Treatment order in the event of an adverse reaction: see label

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? ( )Yes ( )No
Is self- medication permitted and recommended? ( )Yes ( )No
If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.
Do you recommend this medication be kept "on person" by student? ( )Yes ( )No

Printed Name of Licensed Healthcare Prescriber: _____Phone: ( ) _____-_____ Fax: _____-_____

Signature of Licensed Healthcare Prescriber: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____Date: ___/___/___ Phone: ( )

_____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s). **THESE MEDICATIONS ARE NOT TO BE KEPT ON PERSON**

Signature of Parent: _____ Date: ____/____/_____ Phone: ( ) _____-_____

Student's Name:_____ **School Year:**_____

Please indicate your permission for the following Over the Counter medications to be given to your student at _____, as needed, according to the Manufacturers Recommendations.

Please sign for each medication.

Yes	No	OTC Medication	Guardian Signature	Administration Date/Time/Initials (Staff use to chart only)
		Ibuprofen (Advil/Motrin) **1-2 tabs every 4hrs as needed**		
		Acetaminophen (Tylenol) **1-2 tabs every 6 hrs as needed**		
		Diphenhydramine (Benadryl) **25mg tab 1-2 every 6hrs for reaction only**		
		Calcium Carbonate (Tums) **1-2 tabs chewed**		
		Antibiotic Ointment (**Neosporin**/Polysporin) **Thin spread on bandaid**		
		Benadryl Cream Apply to gauze thin spread to rash		

Do not add additional medicines to this form Thank you

_____

_____ **Initial:** _____ **Name:** _____

_____ _____ _____

_____ _____ _____