Rockford Public Schools
Kelly Theaker, BSN, RN
Phone: (616) 863-6031 ext 7030
ktheaker@rockfordschools.org

Medication Authorization Form

Student: ________________________________ Date of Birth: _______________________

School: ________________________ Teacher/Advisor: ____________________________

Grade: ___________________ Date form received by the school: _________________

Medication Policy Reminders:

1. No medications will be administered to a student without written permission from parent or guardian AND physician recommendations. A permission form must be signed and on file for each child who receives a medication at school.
2. New authorization is needed at the beginning of each school year and for each medication.
3. **All medications must be brought to school by parent or guardian.**
4. All medications must be in the original container and appropriately labeled. **School personnel will not administer unlabeled medications.**
5. No medications are to be kept with the student except those required for asthma or allergic reaction. Specific authorization forms must be filled out for Inhalers and EPI pens. See second page.
6. The parent or guardian must pick up unused medications. No medications will be stored over the summer. Remaining medications or contaminated medication will be disposed of properly at the conclusion of the school year.

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of medication: ____

Reason for medication: ____

Form of medication/treatment:

☐ Oral tablet/capsule ☐ Liquid Inhaler ☐ Injection ☐ Nebulizer ☐ Other ______________________

Dose: ______________________ Time to be given at school: ☐ PRN ☐ lunch Other: ____________

If PRN, list symptoms/conditions under which medication is to be given: ____________________________

____

Special Instructions: ____

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes, Please describe:

____

Special storage requirements: ☐ None ☐ Refrigerate

Start: ☐ Date form received Other dates: ____________________________

Stop: ☐ End of school year Other date/duration: ________________________

Physician's Name: ____

Address: ____

Phone Number: ___________________________ Fax: ______________________

Physician's Signature: ______________________________ **Date: ___________**

Physician's stamp

To be completed by parent/guardian

I request that the above named student receive the above medication at school according to standard school policy and for the physician/provider staff and school staff to share information needed to assist my child with his/her health and medication needs. I assume responsibility for safe delivery of the medication to school. I will notify the school immediately if there is any change in the use of the medication or treatment. I release and agree to hold the Board of Education and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

______________________	______________________	______________________
Parent/Guardian Signature	**Printed name**	**Date**

Rockford Public Schools
Kelly Theaker, BSN, RN
Phone: (616) 863-6031 ext 7030
ktheaker@rockfordschools.org

Medication Authorization Form
for Self-Administration/Self-Possession of Emergency Medication

Self-administration means that the student can administer the emergency medication(s) in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, accompanied by an emergency action plan, the student may carry emergency medication on his/her person to allow for immediate and self-determined administration. The school district recommends that spare emergency medication, properly labeled in its original container, be kept in the clinic/office in case the student runs out or forgets the emergency medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian.

Student Name: ___________________________________ Birth Date: ___________ School Year: _____________

To be completed by physician/licensed prescriber:

Start: ☐ Date form received Other dates: _________________________________
Stop: ☐ End of school year Other date/duration: ___________________________

Medication Name	Dose	Time to be Given	Form/Route	Side Effects	Adverse Reaction(s)

List minimal frequency between doses (especially if p.r.n.): ____

If p.r.n., list symptom(s)/condition(s) under which medication is to be given: __________________________________

____

The student is capable of ☐ **self-administering** ☐ **self-possessing** the above medication(s)

____ ___________ ______________________________

Physician's signature Date Physician's Printed Name

Physician's Phone #: ________________________ Fax #: ______________________

Address: ____

To be completed by parent/guardian:

I request and give permission for my child (named above) to: ☐ **self-administer** ☐ **self-possess** the above medication according to school district policy and for the physician staff and school staff to share information regarding my child's health and medication needs.

______________________________________ ________________________ ____________________

Parent/Guardian Signature **Printed name** **Date**

To be completed by student:

I agree to:

1. Never share my medication with another person.
2. Carry the medication in its original, properly labeled prescriptive/over the counter container.
3. Take medication only at the prescribed time/frequency and dose.
4. Keep a copy of this form and back up medication in the school office/clinic.

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardians, and the privilege(s) of self-administration/self-possession denied.

______________________________________ ____________________

Student Signature Date