Student Medication Prescriber Authorization 2020-21

CyberVillage ACADEMY

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- **ONE (1) MEDICATION PER FORM – REQUIRED FOR ALL (PRESCRIPTION & OVER THE COUNTER) MEDICATION**
- Form is required to be completed each school year (or to convey any changes)
- Medication must be submitted in original container / with a printed label from the pharmacy (if prescription) that matches below information
- Medication must be transported to/from school by an adult and locked in the Health Office (unless alternate plan is made with school nurse)

Student Name: _____ Grade: _____ Birth Date: _____

Prescriber Portion

Medication Name: _____ Concentration: _____

Dose: _____ Route: _____ Frequency: _____

Indication or instructions for "as needed" med: _____
_____

Possible Side Effects: _____

For Emergency Medication- The student is capable, has been instructed of the proper use of this medication, and may self-carry / self-administer this medication: Yes ___ No ___ (Check one)

Date: _____ Prescriber Name: _____

Prescriber Signature: _____ Phone/Fax: _____

Parent/Guardian Portion

I request this medication be given as prescribed (above) including on field trips. I release school personnel from any liability in the administration of this medication and understand that I am responsible for communication with the healthcare provider who is ordering this medication. I understand that this medication will not be administered by a school nurse. I understand that this authorization will be effective and need to be renewed each school year. I agree to provide medication in the unopened original container (for over the counter med) / with a printed label from the pharmacy (prescription med) and pick the medication up at the end of the school year (or it will be discarded). I will provide all necessary devices required to administer this medication, if needed (ie: nebulizer mask/tubing, syringes, pill crusher, medcup, etc). Information may be exchanged with staff working with my child, medical providers, and emergency personnel, if needed, to ensure the student's safety.

For Emergency Medication- The student is capable, has been instructed of the proper use of this medication, and may self-carry / self-administer this medication: Yes ____ No ____ (Check one)

Date: _____ Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Phone: _____

Student Medication Parent Authorization Form 2020-21

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Medication Drop-Off/Parent Authorization Form

Would you like to be notified if your student does not take their daily medication? If yes – Please choose: Email ☐ or Phone Call ☐

Notification	Medication #1	Medication #2	Medication #3	Medication #4	Medication #5	Medication #6
Date						
Student Name						
Medication Name						
Dosage to be Given						
Time to be Given						
Quantity in Container						
Prescriber Phone No.						
Parent Name						
Parent Signature						
Parent Email						
Staff Name						
Staff Signature						

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Medication Return

	Medication #1	Medication #2	Medication #3	Medication #4	Medication #5	Medication #6
Date						
Quantity Returned						
Reason for Return (empty bottle, no longer taking, expired, etc.)						
Parent Name						
Parent Signature						
Parent Email						
Staff Name						
Staff Signature						

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