AMITY INTERNATIONAL SCHOOL

Medication Authorization Form 2023

Student Name: _____ DOB: _____ Grade: _____

Parents/Guardians asking school staff to give medications to their child must provide written permission each school year that has been signed by both the parent/guardian and a licensed health care provider, including over the-counter medications, herbals, and supplements.

** Any student with a health condition that could result in an emergency: asthma, seizures, severe allergies, etc., must also submit an emergency action plan provided by their clinic or downloaded from the health office web page** .

Directions: Please fill out one form per medication. All medications must be supplied to the office in original container with pharmacy label and transported by an adult. Medications without completed authorization forms cannot be given.

Physician/Licensed Prescriber Section

I have prescribed and authorized the following medication to be administered by the appropriate trained school personnel:

Medication:_____

Dose/Route:_____

Frequency:_____

Reason for medication: _____
_____

Special Instructions: _____
_____

For emergency medications only (epinephrine injectors, inhalers, etc.):

After discussion with parent/guardian: **(Please tick the appropriate check box below)**

☐ I deem the learner capable of self-carry/administration, and I have explained instructions to the learner.

☐ I deem the learner not capable of self-carry/administration of medication.

_____ Physician Name (printed)

_____ Physician Signature

_____ Clinic Name

_____ Phone Number

_____ Fax

_____Date

Parent/Guardian Authorization

1. I request that the medication be given as ordered during school hours/field trips by school personnel trained by the school.
2. I will notify the school of any change in the medication and will provide new medication before current medication is expired (expired medication cannot be given).
3. I give permission to both, the school Principal and trained school personnel to consult about any questions regarding the medication or health conditions being treated by the medication.
4. I understand that all medication (except emergency medication) must be kept in the Health Office for the safety of all students.
5. For emergency medications only (epinephrine injectors, inhalers, etc.), after discussion with the health care provider, I agree that my child: **(Please tick the appropriate check box below)**

   ☐ May not self-carry.

   ☐ May self-carry and self-administer this medication (Not recommended for elementary students).

I accept all responsibility in the event that the self-carry medication is lost or misused.

I release school personnel from any liability in the administration of this medication.

_____ Parent/Guardian Signature

_____ Name (printed)

_____ Phone Number

_____Date