Prescribed Medical Authorization Form

Students' Name:

Last Name	First Name	Middle Name

I hereby request the school nurse to administer medication to my child as directed by the physician's orders below. I release Green Brook Academy from any liability concerning administration of medication to my child.

Parent/Guardian Signature:_____ **Date:**_____

Medication must be in the original pharmacy labeled bottle and be delivered to the school nurse by the parent/guardian.

PHYSICIAN PERMISSION FOR ADMINISTRATION OF PRESCRIBED MEDICATION DURING SCHOOL DAY

Physicians Orders: (To be completed by Child's Physician)

Please administer the following medication(s) to above stated student as detailed below:

1. _____

Dosage: _____ Time of administration:_____
Duration of administration: (i.e.: 10 days, school year, etc.)

_____

2. _____

Dosage: _____ Time of administration:_____
Duration of administration: (i.e.: 10 days, school year, etc.)

_____

3. _____

Dosage: _____ Time of administration:_____

Duration of administration: (i.e.: 10 days, school year, etc.)

_____

Diagnosis:

_____

Possible side effects:

_____

Physician's Signature (Required): **Date:**

Physician Stamp

PLEASE NOTE:

Requests are effective for one school year only and must be renewed annually. Parent must notify the school nurse in writing when medication is no longer required. If there is a change in dosage a physician's order is required.

Self-Medication by Pupils- Asthma

P.L. 2001 Chapter 61, Authorizes Parents/Guardians to allow their children to self-medicate for Asthma

Students' Name:

Last Name	**First Name**	**Middle Name**

To: Parent/Guardians

Re: Signed Authorization for Self-Medication

I authorized my son/daughter to self-administer the necessary medication for his/her asthma condition. He/she shall be permitted to carry an inhaler. I understand the school shall not incur any liability as a result of any injury arising from the self-administration of medication. I hold harmless the school and its employees against any claims arising out of self-medication by my child.

Parent/Guardian Signature:_____ **Date:**_____

P.L. 2001 CHAPTER 61, WRITTEN CERTIFICATION FROM PHYSICIAN ALLOWING SELF-MEDICATION - ASTHMA

To: Student's Physician

Re: Self-Medication by a Pupil with Asthma

Please be advised that the student stated above has asthma and is capable of, and has been instructed in the proper use and administration of his/her medication.

The student ___ may ___ may not carry the inhaler with him/her at all times.

Please indicate severity of asthmatic condition: _____ Mild _____ Moderate _____ Severe

Physician Signature:_____ **Date:**_____

Physician Stamp: