Tabernacle School
Emergency Medical

Student Information:

Student Name *Date of Birth*

All medications administered to a student must have written authorization from the parent, including over-the-counter medications. Medication will not be administered without a properly completed School Medication Authorization on file in the office. Parents who provide medication must personally deliver an adequate supply to the school office. All medication provided by parents must be in the original container with unaltered label and must be properly labeled with the student's name, medication name, dosage, strength, time interval, route of administration (e.g. by mouth), and expiration date; additionally, prescription medication must be labeled with the prescribing physician's name and the prescription date and number. Parents are notified of medication administration that is not routinely scheduled. Prior to administering as-needed medication, the school will contact a parent to obtain verbal authorization; exclusions include the administration of routinely scheduled medication and emergency medication.

I authorize Tabernacle School or their designee to assist in administering the below medication to my child in accordance with my request and/or the physician's written instructions below. I understand that for medication prescribed or indicated by a physician, parent instructions for medication administration may not conflict with the physician's instructions; I understand that for medication not prescribed or indicated by a physician, parent instructions for medication administration may not conflict with the medication label directions. I agree to notify the school in writing as soon as possible of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on this School Medication Authorization or on the physician's instructions or treatment plan. I agree to, and do hereby hold Tabernacle School and Preschool and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to the medications listed below. I hereby give consent for the school to communicate with school personnel and my child's health care providers as needed with regard to the medications and the care of my child's health.

I authorize the below over-the-counter medication (provided by the school) to be administered to my child. I have checked the appropriate medication to be administered.

- ☐ Junior strength acetaminophen (ages 2-11) given per manufacturer's directions. Liquid or tablet
- ☐ Junior strength ibuprofen (ages 2-11) given per manufacturer's directions. Liquid or tablet
- ☐ Children's diphenhydramine (Benadryl or generic) (ages 6 and over) given per manufacturer's directions. Liquid or tablet
- ☐ Regular strength acetaminophen (ages 12 and over) given per manufacturer's directions.
- ☐ Regular strength ibuprofen (ages 12 and over) given per manufacturer's directions.

I authorize the below over-the-counter medication I provide.

Name of Medication _____ Reason _____

Dosage _____ Dosage Frequency _____

_____ _____ _____ _____

Signature of Parent | Date | Emergency Phone #1 | Emergency Phone #2

TO BE COMPLETED BY THE PHYSICIAN FOR PRESCRIPTION MEDICATION

and for over-the-counter medication for which a physician's instructions are needed to comply with or to supersede medication label directions

The child named above is under my care. It is necessary for him/her to receive the following medication during school hours.

Name of Medication _____ **Diagnosis for which medication is taken** _____

Dosage _____ **Frequency/Time(s)** _____

If the medication is for EMERGENCY TREATMENT, please attach an EMERGENCY SPECIFIC TREATMENT PLAN

Does medication require refrigeration? Yes ☐ No ☐ Is the medication a controlled substance? Yes ☐ No ☐

Method of Administration ☐ Liquid ☐Tablet ☐ Inhaler ☐ Drops ☐Topical ☐ Other _____

Is self-medication permitted and recommended for this student? Yes ☐ No ☐

If yes, do you recommend this medication be kept "on person" by the student? Yes ☐ No ☐

If yes, has the above student been instructed and shown competency in use of the life sustaining medication? Yes ☐ No ☐

Specific Indications for Administering Medication _____

Potential Side Effects/Contradictions/Adverse Reactions _____

_____

Treatment Order in the Event of an Adverse Reaction _____

_____

Signature of Physician _____ **Office Telephone** _____

Print Name and Address _____ **Date** _____