Rising Tide Charter Public SchoolAuthorization for Prescription Medication Administration

Student's Name: _____ DOB: _____ Grade: _____
Medication Name: _____
Parent/Guardian Name: _____
Address: _____
Home Phone: _____ Cell: _____ Work: _____

PARENT/GUARDIAN CONSENT:
Please address each of the following:

1. I request and give permission to the school nurse or trained and designated school personnel to administer this medication to my child as prescribed. **Yes No**
2. I give permission for my child to self-administer this medication if the school nurse determines it to be safe and appropriate. I understand that the Medication Self-Administration Plan on the back of this form needs to be completed if I select this option.
   Yes No
3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration as she determines necessary for my child's health and safety. **Yes No**
4. I understand that in the event of a field trip the medication administration plan may need to be adjusted. **Yes No**
5. I give permission to the school nurse or trained and designated school personnel to administer this medication to my child as prescribed during a field trip. **Yes No**
6. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following the termination of the order of the last day of school. **Yes No**

Parent/Guardian Signature: _____ Date: _____

LICENSED PRESCRIBER

Diagnosis: _____
Allergies: _____
Medication: _____ Dosage: _____
Route: _____Frequency: _____Time of administration at school: _____
*Whenever possible, medications should be scheduled at times other than school hours.
Adverse Effects: _____
_____
Effective Dates: ___/___/_____to ____/____/____
Consent for self-administration (provided the school nurse determines it is safe and appropriate)
Yes No
Name of Licensed Prescriber (print): _____ Title: _____
Signature of Licensed Prescriber: _____ Date: _____

Rising Tide Charter Public School
Self-Administration Prescription Medication Plan

Please note that self-administration is usually reserved for inhalers, Epi-Pens, glucose monitoring tests, and insulin delivery systems. Once completed and signed, this form may be copied and given to the student for whom self-administration is determined to be appropriate. The original is to be retained by the school nurse in the medication book. The medication is to be entered and recorded in the computerized health record for inclusion in the medication statistics.

Student Name: _____ DOB: _____ Grade: _____
Medication to be taken: _____
Route: _____ Time: _____
Instructions: _____
_____
_____
Amount of medication to be carried by the student: _____

How will medication be carried by the student?
- € Backpack
- € Pocketbook/purse

Where will replenishing of medication be done?
- € In the Nurse's Office
- € At Home

When should the student go to the Nurse's Office?
- € At the end of each school day
- € At the end of each week
- € When medication orders change

If I have the following side effects/symptoms, I should go to the Nurse's Office:
_____
_____
_____

Student Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
Nurse's Signature: _____ Date: _____

Plan Discontinuation:
Reason: _____ Effective Date: _____
Authorized by: _____
Signature: _____

MEDICATION ADMINISTRATION PLAN (To be completed by school nurse)
Medication: _____ Date ordered: _____
Expiration Date: _____ Time to be given: _____
IHCP: Yes/No Refrigerate: Yes/No Order received: Yes/No
Nurse's Signature: _____