PHILLIPS Programs
Medication Authorization Form
Parental and Licensed Prescriber Authorization
School Year _____

Student's Name: _____

Grade: _____ DOB: _____

Allergies: _____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while in PHILLIPS Programs. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release PHILLIPS Programs and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

Medication must be sent to school in the original pharmaceutical container. The container must have the child's name, the time the medication should be given, the route the medication is to be given, the dosage of medication to be given, and the prescriber name.
The medication may be delivered by you personally, or transported by PHILLIPS bus driver only. It is against policy for PG, MGPS, DCPS and other jurisdictions to transport medication. Please check with your child's family service provider here at school if you have any questions concerning transporting medication to school.

Date of last tetanus shot: _____

Tylenol/ Acetaminophen may be given to my child during the school hours as needed for pain.

Circle: YES or NO

Please be advised the following doses will be administered:
6-11 years old - Acetaminophen 320 mg (liquid/chewable tablet) by mouth every 6 hours as needed for pain, not to exceed 3 doses in 24 hours
12-18 and over years – Acetaminophen 650 mg (cap/tab) by mouth every 6 hours as needed for pain, not to exceed 3 doses in 24 hours.
If you are requesting a different dose of the pain medication be administered then you must complete a Medication Authorization Form

_____ _____ _____
Parent/Guardian Signature **Daytime Phone** **Date**

Medication Authorization
(For Use By Licensed Prescriber ONLY; use one form for each medication)

Student's Name: _____

Relevant Diagnosis _____ Medication _____

Dates medication must be administered at school:
_____ Short Term (List dates to be given): _____
_____ Every Day at school
_____ Episodic/Emergency Events ONLY
Dosage (Amount): _____ Route: _____ Form: _____
Time(s) of Day: _____

Serious reactions can occur if the medications is not given as prescribed: YES/NO
If yes, describe: _____
_____

Serious reactions/adverse side effects from this medication may occur: YES/NO
Please list: _____
_____

Action/Treatment for reactions: _____

Report to you: YES/NO

Special Handling Instructions: _____

Asthmatic/Diabetic ONLY

This student is both capable and responsible for self-administering this medication:

_____ NO _____ YES-Supervised

_____ YES-Unsupervised

This student may carry this medication _____NO _____ YES

Licensed Prescriber's Name _____

Telephone Number _____ Emergency Number _____

Licensed Prescriber's Signature_____ **Date**_____