Alpine Academy of Rockford

Authorization for Administration of Medication

School Year: _____

Alpine Academy of Rockford requires that this form be completed by both the physician and parent/guardian before any prescription medication can be given during school hours.

All medication sent to school must be:

1. In the original prescription bottle or container.
2. Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, and the time the medication is to be given.
3. Dropped off in the school office by the parent/guardian.

_____ _____ _____

School Nurse | Phone | Fax

Physician Authorization

Student's Name:_____ Date of Birth _____

Medication:_____

Dose, Route, and Time:_____

Possible Side Effects:_____

Reason for the Medication:_____

Other Medications:_____

Approval for Self-Administration

_____

(Field trips or medication required at time when nurse is not in the building) (Indicate yes or no)
Self-administration will be under the supervision of voluntary school personnel.

Approval for student to carry and use emergency medication (Inhaler/Epi-pen)

_____

(Recommend age 10 years and over only) (Indicate yes or no)

Physician Signature:_____

Physician's Name (Please Print)_____Phone:_____

Parental Authorization

I authorize Alpine Academy of Rockford and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-administer while under the supervision of the employees and agents of this school district) to my child this lawfully prescribed medication and any prescribed changes. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a l nurse and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school district, its employees and agents arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify the District and its employees from any and all claims, damages, causes of action or injury incurred or resulting from the administration or attempts at administration of said medication. I allow the nurse (listed above) to discuss this medication and its effects on my child with the prescribing physician or his representative.

Parent/Guardian Signature: _____ Date:_____ Phone_____

#1:_____ Phone #2: _____

11/2007, revised; 4/2010