AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL (Med Form 3)

Bob Jones Academy

Must be signed by parent and physician

Please print

School year _____

Student's name _____ Date of birth _____

Parent or Legal Guardian _____ Daytime phone _____

Name of medication _____

Reason for taking medication at school (please be specific) _____

_____

Amount of medication to be taken _____

Time medication is to be taken at school _____

Date to ***start*** medication _____ Date to ***stop*** medication _____

Possible side effects _____ Expiration date of medication _____

Parents please read carefully:

Working closely with our physician we have decided to allow my child to self-administer and self-monitor the above medication while at school. My child has been trained by our physician and has demonstrated competency in this procedure. My child must be allowed to possess this medication at school-sponsored activities, in transit to and from school or school-sponsored activities, and during before- or after-school activities on school property. I realize that Bob Jones Academy can not be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with other school personnel who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions.

Parent or Legal Guardian's signature _____ Date _____

Physician please read carefully:

I agree that this student must be allowed to have the above named medication on his/her person during school hours, in transit to and from school or school-sponsored activities, during before- and after-school activities on school property, and any school sponsored activity. This child has demonstrated competency in self-monitoring and self-administration of this medication. The parent is aware that they can not hold the school responsible for any adverse outcome of this action.

Physician's signature _____ Date _____

Office phone _____

School nurse or designee _____

Phone _____ Email _____

BJA 017/05 (16801) 3/14