BOB JONES ACADEMY

Rev 6/2024

Authorization For Prescription Medication at School

- *Please complete a separate form for each medication.*
- *Medication must be brought to the school nurse by a responsible adult (do not send medication with a student.)*
- *Medication should routinely be given at home before or after school whenever possible.*
- *All prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.*
- *If the information on the authorization form does not match the prescription label, the medication will not be accepted.*
- *Herbal/alternative medical products will not be administered in the school setting.*
- *Medications will not be administered without this completed form, including the required signatures.*

Student's Legal Name:	Date of Birth:	Current Weight: ________lbs.	List Allergies:
Name of Prescription Medication to be given at school:		**Purpose** of Medication at School:	
Prescribed Dose (i.e. 5 mg, 10 mg, etc.)		**For Liquid Medication Only**: Dose=_______________ ml	
Prescribed Time of Day for administration at school: (specific time i.e., 8 a.m., "after breakfast", or "lunchtime")	**Prescribed Route** (i.e., oral, inhaled, rectal, etc.)		**Special Instructions:** (i.e., crush, give with applesauce)
Date to Start Medication:		**Date to Stop** Medication:	
List possible side effects:			
The physician that prescribed this medication:		Phone:	

Parents/Legal Guardians Please Read Carefully:
By signing below, I understand and agree to the following:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the school nurse(s) and/or designated staff to share this information with individuals who have responsibility for my child.
- The first dose of any new medication will be given at home so that I can monitor for adverse reactions.
- I give the school nurse my permission to contact the above-named Licensed Healthcare Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for the school nurse or designated BJA staff to administer this medication to my child according to school policies.

Parent/Legal Guardian Signature:____ Date:__________________________

Parent/Legal Guardian Printed Name:_____________________________________ Daytime Phone Number:__________________

This form is only valid if signed on or after July 1st for the upcoming school year.