

The Cardinal Hickey Academy

Owings, Maryland 20736

Medication Prescriber/Parent Authorization Form:

Request to Administer Medication During School Hours – 2009-2010 School Year

(Use a separate form for each medication order)

Student Name _____ D.O.B. _____ Teacher _____ Grade _____

NOTE: The administration of medication in the school setting is a service offered to parents/guardian and students to promote wellness and decrease absenteeism. Employees of the Cardinal Hickey Academy **can not** administer medications, including over the counter drugs, without the written authorization from parent/guardian **AND** authorized prescriber. The parent/guardian is responsible for providing all information needed for the proper administration of medication. A confirmation of current medications which must be administered during school hours must be made or renewed at the beginning of each school year. Whenever there is a change in medication, the parents must have a new form completed by the physician.

To be Completed by Authorized Prescriber:

Medical Diagnosis: _____ Allergies _____

Medication _____ Dosage _____ Frequency _____ Route _____

Side Effects _____ Adverse Reactions _____

Start Date _____ Stop Date _____ Special Instructions _____

If PRN a) For what symptoms _____ b) How often? _____

Authorized Prescriber (Print Clearly) _____ Phone # _____

Authorized Prescriber Signature _____ Date _____

The parent/guardian is responsible to provide this completed form, the medication in its original container and a current emergency form. The initial dose of a new medication must be given by the parent/guardian.

THE MEDICATION WILL NOT BE TRANSPORTED BY THE STUDENT

I request and give permission for (name) _____ to receive the above medication according to Cardinal Hickey Academy School Policy. I allow the authorized prescriber and the school nurse to share information regarding medication issues.

Parent?Guardian Signature _____ Date: _____ Phone _____