



Debbie School



Phone: (305) 243-6961 – Fax: (305) 243-3155

MEDICATION ADMINISTRATION AUTHORIZATION

Child's Name: _____ **D.O.B.** _____

The Debbie School shall administer medications for children only when requested by the prescribing physician. Each container shall be childproof and carry the name of the medication, the name of the person for whom it was prescribed, the name of the prescribing physician, and the physician's instructions. Each child's medication shall be stored in its original container. No medication shall be transferred between containers. This is in compliance with state and federal laws.

PHYSICIAN AUTHORIZATION (to be completed by physician)

The above named child is under my medical supervision. I have prescribed the following medication:

Possible adverse reactions of the medication

Condition requiring medication

Amount to be taken/Dosage

Time of day to be given/Frequency

Length of time medication is needed/Start Date-Stop Date:

Physician's name

Phone

Physician's signature

Date

LEGAL GUARDIAN PERMISSION (to be completed by child's legal guardian)

I hereby request that my child be given the above prescribed medication while in school and away from school for activities. I understand that the law provides that there shall be no liability for civil damages as a result of the administration of such medication were the person administering such medication acts as an ordinarily reasonable prudent person would have under the same or similar circumstances. I understand that I must notify the school of any changes in my child's medication. I understand that I am responsible for ensuring that the medication arrives safely at school and for refilling the medication prescription as needed.

Name

Home Phone

Signature

Work Phone

Date

Emergency Phone