Einstein School ("School")

AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

Student Full Name ("Student"):_____

Medication Name: _____ Time: _____ Dosage: _____

Start/End Date: _____ Allergies: _____

Does the Medication require refrigeration? Yes _____ No _____

Special Instructions:

Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or non-prescription medication when dosage is more than the recommended dosage on the container require a signed physician's order for administration of the medication by the Einstein School. The Einstein School will not administer experimental medications or medication doses that exceed those approved by the US Food and Drug Administration.

All prescription medications must be brought to school in the current original container with pharmacy label intact. The label must have the student's name, name of medication, dosage, and time to be given. All over-the-counter medications must be in an unopened original container. Student's name must be written on the box/bottle, and the dosage and frequency to be given must be consistent with label instructions.

*******Medication cannot and will not be accepted in baggies or envelopes********

PHYSICIANS: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION.

Medication:_____/_____ Trade Name / Generic Name
Dosage: _____ Time(s) to be given at School: _____
Method of Administration: ORAL: Liquid Tablet Inhaler DROPS: Eye: R L Ear: R L
TOPICAL: Apply where: _____ OTHER: _____
Effective Dates: From _____/_____/_____ To _____/_____/_____
Possible Side Effects: _____
Signs and Symptoms
If Medication is PRN (as needed), please specify: _____

_____
Can Medication be Repeated? Yes No How Many Times? _____ Frequency of Administration

Does the Medication require refrigeration? Yes_____ No _____

Special Instructions:

Physician's name (print): **Physician's signature:**

Phone number: **Fax number:** **Date:**

The Student has not experienced any side effects from the medication I am asking the School to administer. The Student does not have any allergies, medical conditions, illnesses, injuries or any other condition which could adversely affect the Student taking the medication I am asking the School to administer. I understand, if the School needs to contact the Student's physician, I may need to complete paperwork to do so, and in the meantime, I understand the School may not administer any medication. I further understand the School, in its sole and absolute discretion, may cease administration of medication to the Student for any reason at any time.

I understand any remaining medication must be picked up by me on or before the last day of school or the medication will be destroyed. I agree to provide medication and any ancillary items connected with administering medication at my expense. I will promptly notify the School of any change in the administration of this medication and will provide the school with new prescriptions and/or bottles, as well as a new Authorization and Permission for Administration of Medication. I understand that written or verbal changes to medications from me will not be accepted.

I hereby request and consent to personnel at the School administering over the counter and/or prescription medication to the Student and authorize the School to share the Student's health/medical information with appropriate personnel for purposes of educational evaluation/planning, program evaluation/planning, health assessment, planning for health care services and/or treatment, and medical evaluation or treatment by other health care providers and facilities. I acknowledge that the School is not a health care facility and that the School's personnel is comprised of non-licensed health care professionals and a nurse(s). The School has made no guarantees to me as to the qualifications of School personnel or to the School's ability to respond to any serious or emergency medical needs of Student.

In consideration of the School administering over the counter and/or prescription medication to the Student, I agree that, in the event of any injury or damage to the Student that may relate to, arise out of, or in any way concern the medication given to the Student and/or medical support to the Student, I release the School and its employees and agents from any and all liability whatsoever that may arise from any accident, injury or property loss occurring as a result of the medication given to the Student and/or medical support services provided and from any responsibility and/or liability for the acts or conduct of the Student. Further, I WILL HOLD HARMLESS AND WILL INDEMNIFY THE SCHOOL AND ITS AGENTS AND EMPLOYEES AGAINST CLAIMS, CAUSES OF ACTIONS, AND DAMAGES FOR WHICH THE SCHOOL MAY BE SUED OR BECOME LIABLE BY REASON OF SUCH INJURY OR DAMAGE, WHETHER BROUGHT BY THE STUDENT OR AGAINST THE STUDENT OR BY ANY PERSON HAVING A LEGAL INTEREST IN THE PROPERTY OR PERSON OF THE STUDENT.

Parent Name: _____

Parent Signature: _____ Date:_____