AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICATION

USE A SEPERATE AUTHORIZATION FORM FOR EACH MEDICATION

Student's Name _____

PARENTAL CONSENT

I am the parent or legal guardian of _____ . I give my permission for him/her to take the following prescribed medication while attending the Virginia Governor's School for Agriculture. I hereby release the Virginia Governor's School for Agriculture and its agents and employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless of any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber."By typing or drawing my signature below, I acknowledge that it is my intent to electronically sign this document and agree to the use of electronic records for the purposes provided herein."

_____ _____ _____

Parent/Legal Guardian Signature Daytime Phone Date

****

MEDICATION AUTHORIZATION

(This section to be completed by **Licensed Prescriber** only! Please print or type.)

Relevant Diagnosis (please describe any problems associated

Medication: _____

Dates medication must be administered at school: ◯ Short Term _____ - _____
◯ Every Day
◯ Episodic/Emergency Events ONLY

Dosage (Amount): _____Route: _____Form: _____Time(s) of day: _____

A.Can serious reactions occur if the medication is not given at the time prescribed, or if a dose or dosages are missed?
If YES, please describe:_____

BDo serious reactions/adverse side effects from this medication occur? If YES, please describe:

C.Action treatment for reactions: _____
(Drug information sheet may be attached)

Special handling instruction: ◯ Refrigeration ◯ Keep out of sunlight ◯ Other: _____

This student is both capable and responsible for self-administering this medication:
◯ No ◯ Yes-supervised ◯ Yes-unsupervised

The Governor's School assumes students are medically stable and able to self-administer all prescribed medications. If there are any contradications or disabilities that would preclude this student from self-administration of medication, please explain on the reverse of this form.

Licensed prescriber's name: _____ _____ Telephone number: _____
Emergency number: _____

Prescriber's Signature: _____ Date: _____

"By typing or drawing my signature above, I acknowledge that it is my intent to electronically sign this document and agree to the use of electronic records for the purposes provided herein."