MEDICATION AUTHORIZATION FORM
Health Center fax (401) 752-2694

Student Name_____ Date of Birth _____
(Last) (First)
Address_____ Phone_____

I understand that special permission is required for use of medication by students during school hours. I request that my child be permitted to self-carry/self-administer as authorized by both me and my child's physician. I recognize that the school will not be able to track compliance with the medication dosing schedule. It will be my responsibility to ensure compliance. As a parent/guardian of the student, I agree to hold harmless and indemnify the school and The Metropolitan Regional Career and Technical Center's employees and agents against all claims, judgments or liabilities arising out of self-administration and carrying of medication by their student.

For medication other than inhalers, only that day's supply of medication is to be carried.
Parent/Guardian Signature_____ Date_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Medication_____

Dose_____ Route_____ Time_____ Frequency_____

Describe Indications _____

Potential Side Effects _____

Related Diagnosis_____

Other Information_____

** This child is authorized to self- carry and / or self-medicate in school, on a field trip or during an activity away from school Yes_____ No_____

Physician Signature_____ Date _____

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Student Name _____

To be completed by student

I agree to:

1. Never share my medication with another person.
2. Carry the medication in its original properly labeled prescription or over the counter container.
3. Take the medication only at the prescribed time, frequency and dose.

I am knowledgeable regarding the dose, desired effects, administration, etc of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian, and the privilege of self-administration/self-carry will be denied.

Student Signature _____ Date _____