Hartland
DAY ACADEMY

Authorization/Parental Consent for Administering Medication

(Use a separate authorization form for each medication)

STUDENT'S LAST NAME _____, **FIRST NAME** _____, **M.I.** _____

GRADE ____ **DATE OF BIRTH** _____

Allergies _____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while in **Hartland Day Academy**. I hereby acknowledge that I have read and understood the Regulations in the school handbook relating to the taking of medications. I hereby release **Hartland Day Academy** and its employees from any claims or liability connected with its reliance on this permission and agrees to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. *I* authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

_____ _____ _____

Parent/Guardian Signature Daytime Phone Date

MEDICATION AUTHORIZATION
(For Use by Licensed Prescriber ONLY)

Relevant Diagnosis _____ Medication _____

Dates medication must be administered at school: ___ Short Term (List dates to be given _____)

___ Every day at school ___ Episodic/Emergency Events ONLY

Dosage (Amount) _____ Route _____ Form _____ Time(s) of Day _____

A. Serious reactions can occur if the medication is not given as prescribed: ☐ YES ☐ NO

If yes, describe:

B. Serious reactions/adverse side effects from this medication may occur: ☐ YES ☐ NO

If yes, describe:

Action/Treatment for reactions: _____

Report to you: ☐ YES ☐ NO (Drug information sheet may be attached.)

Special Handling Instructions: ☐ Refrigeration ☐ Keep out of sunlight ☐ Other _____

Asthmatic/Diabetic ONLY

This student is both capable and responsible for self-administering this medication:
☐ NO ☐ YES - Supervised ☐ YES - Unsupervised

This student may carry this medication: ☐ NO ☐ YES

Licensed Prescriber's Name _____ Signature_____

Telephone Number _____ Emergency Number _____ Date_____