

THE BARSTOW SCHOOL

Summer 2008

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATIONS

Name of Student _____ Fall Grade _____

Prescribed medications must have intact prescription labels and a (non-parent) physician-signed authorization form must be on file before school personnel will administer them. If a change in type of medication or dosage is warranted, a new request signed by the parent and/or (non-parent) physician must be provided.

All medications must be kept in the health office and administered according to label instructions and at the discretion of school personnel. In rare circumstances, a student may contract with the school nurse to carry his/her own inhaler, but only after strict criteria have been met. Otherwise, all medications are administered by school personnel, even on field trips. This policy exists for the safety of all students; your cooperation is greatly appreciated!

Required For Prescription Medication

Prescription

Medication _____ Dosage _____

Time of Day _____ Reason _____

I prescribe and authorize administration of this medication to the above named student.

Signature of (non-parent) Physician

Date

Print Name of Physician or attach photocopy of current pharmacy label