

Premier Academy Authorization/Parental Consent for Administering Medication

(Use a separate authorization form for each medication.)

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

SIS NUMBER _____ 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 at **Premier Academy**. I hereby acknowledge that I have read and understood the Premier Academy rules relating to the taking of medications. I hereby release **Premier Academy** and its employees from any claims or liability connected with its reliance on this permission and agree 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 licensed prescriber listed below.

Parent/Guarding Name (Please Print)

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 _____

Telephone Number _____ Emergency Number _____

Licensed Prescriber's Signature _____ Date _____

Upon completion of the form, please fax to
Premier Academy, Morris Campus at 815.828.0639
Thank you.