Starmaker Learning Center
23443 Cottonwood Parkway
California MD 20619
301.863.7740 fax 301.863.6659

PARENTAL AUTHORIZATION FORM: MEDICATION

I hereby give my permission for _____ to take

_____ at school as ordered by the physician, nurse practitioner or dentist.

(name of medication)

I understand that it is my responsibility to furnish this medication. I understand that the medication must be brought to school in the original pharmacy container appropriately labeled. This includes my child's name, name of medication, dosage, time of administration, route, name of prescriber, date of medication order, and expiration date of drug. _____ (Initials)

I further understand that any school employee who administers any drug to my child, in accordance with written instructions from the prescriber and Starmaker Learning Center, shall not be liable for damages as a result of an adverse drug reaction suffered by my child due to the administration of the drug. _____ (Initials)

I further understand that *each* time my child is prescribed an antibiotic that my child may not return to Starmaker Learning Center until twenty-four (24) hours after the first dose of the antibiotic. This policy is a safety precaution for the child in the event that an allergic reaction occurs. _____ (Initials)

Medication(s) Given at Home: _____

_____

Side Effects: For all medications given at home, list all side effects which may be observed by school personnel:

_____

_____

Date:_____ Parent/Guardian Signature_____

When this form is completed and signed by both physician and parent, return it to the Medication Assistant at Starmaker Learning Center with the prescribed medication in the original pharmacy container. Thank you.

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PHYSICIAN AND PARENTAL AUTHORIZATION FORM
MEDICATION ORDERS

(to be filled out by physician ordering medication)

Note: If possible, arrange time of dosage so that medication(s) will not have to be given while the child is in school.

PHYSICIAN'S AUTHORIZATION FORM: MEDICATION

Date of Order _____

Name of Student _____ D.O.B. _____

Medical Diagnosis _____

Medication _____ Dosage _____
ONE (1) FORM PER MEDICATION

Time of Administration _____ Route of Administration _____

Duration of Administration Start Date _____ Stop Date _____

Is this medication to be self-administered? _____ Yes _____ No
(Students who self-administer will demonstrate their skill to the medication assistant and follow school medication guidelines.)

Other Medication(s): _____

_____

Side Effects: For all medications, list all side effects which may be observed by school personnel:

_____

_____

This form must be kept current. Whenever there is any change in medication or dosage, the parents must have a new form completed by the physician. All medication orders must be renewed at the beginning of each school year.

Physician's Signature _____

Physician's Name (Print Clearly) _____

Date _____ Telephone Number _____

PARENTS MUST COMPLETE REVERSE SIDE