BEAUMONT SCHOOL

2016-2017
Physician Authorization and Parental Request for All Medications

Student's Name _____

Grade or Homeroom _____ Date of Birth _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for medication: _____

Name of medication: _____

Medication form: ___Tablet/Capsule ___Liquid ___Inhaler ___Injection ___Other:_____

Special Storage Requirements: ___refrigerate ___none ___other: _____

Start date: _____

Stop Date: _____ End of school year _____ Other/duration _____ For episodic/emergency events only

Instructions (schedule and dosage to be given): _____

_____

Restrictions/side effects: _____

_____

If prescribing an **Epipen** or **Rescue Inhaler**, is the student capable and responsible for self-administering this medication? ___No ___Yes (supervised) ___Yes (unsupervised)

May the student carry the **Epipen** or **Rescue Inhaler**? ___Yes ___No

Procedure to follow in event medication does not produce expected relief _____

_____

Date: _____Signature: _____
Authorized prescriber

Date:

Reviewed by Nurse:

Physician's name printed: _____
Address: _____
Phone number: _____Emergency number: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, _____to receive the above medication at school or field trips according to Beaumont School policy. It is understood that Beaumont School and all of its personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand the medication must be brought to school in its original container or the container to which it was dispensed from the pharmacist.

Date: _____ Signature of Parent/Guardian: _____

Address: _____ Phone Number _____