



AUTHORIZATION FOR MEDICATION

In order to help protect your child's health, your consent and written authorization from a licensed healthcare provider are required when it is necessary for your child to receive either prescription or non prescription medicines at the Monroe Charter Academy. No medications will be given to your child at school until this authorization form has been received. A separate form is required for each medicine. New authorization forms are required every year at the beginning of school, whenever the DOSE or DIRECTIONS CHANGE, or when a new medicine is prescribed. Each medicine must be in an appropriately labeled ORIGINAL container from the pharmacy or healthcare provider's office. Most pharmacies will provide an extra container for school use upon request. A completed authorization form is also required for the administration of non-prescription medicines to be given at school. This must be signed by your child's doctor. This is not the form for self carry.

STUDENT'S NAME _____ **TEACHER** _____ **GRADE** _____

PARENT OR GUARDIAN'S PERMISSION: I give permission for my child to receive the medicine described below during school hours. I understand that it is my responsibility to purchase and supply this medicine. On behalf of my child, I absolve Monroe Charter Academy and their employees from any and all liability whatsoever that may result from my child taking this medicine at school.

Signature of parent or guardian: _____ **Date:** _____
Contact numbers: _____

FOR LICENSED HEALTHCARE PROVIDER USE ONLY: (Please write legibly using lay terms)

Specific Directions: (Please include exact amount to give, at what times and/or how often, relationship to meals, specific indications, e.g. if prn (as needed))

Purpose of medication: _____

Medication prescribed: _____ **Strength/dose:** _____

Side effects/adverse reactions: _____

Any other instructions including emergency situations that may arise: _____

LICENSED PHYSICIANS SIGNATURE: _____ **DATE:** _____



AUTHORIZATION FOR MEDICATION FOR STUDENT TO SELF CARRY

This student should carry the medication with him/her at all times during the school day, while at school-sponsored events, or while in transit to or from school or school sponsored activities.

Parent or Guardian: I hereby give permission for my child to self carry his/her medication that is hereby prescribed by the physician. I have explained to my child the importance and the responsibility of what it means to self carry the medication.

Parent Signature: _____ Date:

FOR LICENSED HEALTHCARE PROVIDER USE ONLY:

Name of medication : _____

Dose/how often to be administered: _____

I have given instructions to the student and parent on how to self carry and self administer this medication as directed and deem it necessary for the student to self carry.

Healthcare Provider's signature: _____

Date: _____

Practice name and address: _____

Phone: _____ Fax: _____

Student: I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will NOT share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when the medication is to be used.

Student signature: _____ **Date:** _____