River Region Academy

Prescription Medication Authorization 2023-2024

Student's Name ____ DOB _______________ Grade ____

☐ No known drug allergies – if drug allergies, list:____

Prescriber Authorization (to be completed by licensed healthcare provider)

Name of Medication ____ Dosage _________________

Time/Frequency to be given _____________________________________ Route __________________

Reason for taking medication ____

Is self-medication permitted and has student been instructed on proper self-administration of the prescribed medication? YES NO

Do you recommend this medication be kept 'on person' by the student? YES NO

Printed Name of Licensed Healthcare Provider ____

Signature of Licensed Healthcare Provider ____

Phone Number _________________________________ Date __________________________________

Parent/Guardian Authorization

I authorize an administrator or designated employee of River Region Academy to administer the above medication to my student. I understand that additional signed statements will be necessary if the medication or dosage is changed. I understand that prescription medication must be properly labeled with student's name, prescriber's name, dosage, times/intervals, and route of administration.

Parent's/Guardian's Signature ____

Phone Number _________________________________ Date __________________________________

Self-Administration Authorization

(to be completed only if student is authorized to self-administer by licensed healthcare provider)

I authorize self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper administration by a licensed healthcare provider. I shall indemnify and hold harmless the school and any agents/affiliates of the school against any claims that may arise relating to my child's self-administration of the prescribed medication.

Parent's/Guardian's Signature ____

Phone Number _________________________________ Date __________________________________