River Region Academy

Prescription Medication Authorization 2024-2025

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 _____