River Region Academy

Prescription Medication Authorization

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.

I understand that while school staff will make reasonable efforts to administer medication as prescribed, I agree to hold River Region Academy, its employees, and agents harmless from any liability or claims arising from the administration or failure to administer the prescribed medication. All medication must be delivered to the school by a parent/guardian or responsible adult. Students may not transport medication unless authorized for self-administration. This authorization may be revoked in writing at any time by the parent/guardian.

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 _____