MEDICATION AUTHORIZATION (Parent/Guardian)

East Greenwich Public Schools
111 Peirce Street
East Greenwich, RI 02818
(401) 885-3300

Student Information

Name:_____ D.O.B_____

Address:_____ Phone:_____

School:_____ Grade/Teacher:_____ Academic Year_____

Physician's Name:_____ Phone:_____

Medication

Medication Name:_____

Category:

- ❑ **Written Order** MD Signature: _____
- ❑ **Non-Prescription** Date: _____
- ❑ **Inhaler/Nebulizer**
- ❑ **Epi-Pen**

Dose: _____

Approximate Dispensing Time: _____

Route: _____

*Frequency:*_____

*Off-Site or Self-Administration:*_____

Reason for Medication:_____

AUTHORIZATION

- I authorize appropriate personnel to administer the above medication (per Standing Orders) to my child in my absence.
- I further understand that it is my responsibility to **refill medications** when they are expended and to transport medication refills to school as soon as possible. The nurse/teacher will send home empty vials or packaging with my child which will serve as notification of the need for renewal. **I am aware of the expiration date and assume responsibility for refilling this medication as necessary. I understand that no medication will be stored in the school during the summer vacation and may be discarded.**
- **Should any student transport medication to school, it must be stored safely out of sight. Medication must not be opened, shown, and/or given to anyone on route to the school office. If any violation occurs in this procedure, the student will lose the privilege of delivering his/her own medication to school.**
- In **special circumstances** such as self-administration or off-site administration, I am aware that it may be necessary to meet to further clarify certain procedures and/or sign an agreement related to my child's medication needs.

PARENT/GUARDIAN SIGNATURE_____ **Date:**_____

Attachments:

- ❑ Written Order
- ❑ Individual Plan for Self-administration of prescription medication (excluding Schedule II)
- ❑ Off-Site Administration

Revised: 11'06