

## AUTHORIZATION TO ADMINISTER MEDICATION

**\*\*\*This form must be signed by physician AND parent/guardian.\*\*\***

**Student Name:** \_\_\_\_\_  
*Last First Nickname*

**Date of Birth:** \_\_\_\_\_  
**Date of Admission:** \_\_\_\_\_

<b>TO BE COMPLETED BY THE PHYSICIAN</b>	<b>PRESCRIPTION MEDICATION TO BE ADMINISTERED AT SCHOOL</b>		
	<b>Medication Name</b>	<b>Dosage</b>	<b>Time &amp; Frequency</b>
	<b>Intended Effect of Medication:</b>		
	<b>Specific Instructions:</b>		
	<b>Common Side Effects:</b>		
	<b>Medication is for:</b>		
	<b>OVER-THE-COUNTER MEDICATION (as needed)</b>		
	<input type="checkbox"/> Ibuprofen (i.e., Advil, Motrin)	Dosage: _____ 200 mg every _____ hours	
<input type="checkbox"/> Acetaminophen (i.e., Tylenol)	Dosage: _____ 500 mg every _____ hours		
<input type="checkbox"/> Calcium Carbonate (i.e., Tums)	Dosage: _____ 1,000 mg every _____ hours		
<input type="checkbox"/> Antihistamine (i.e., Benadryl)	Dosage: _____ 25 mg every _____ hours		

<b>PHYSICIAN AUTHORIZATION</b>	<b>Physician Name:</b> <small>(please print)</small>		
	<b>Address:</b>		
	<b>Phone Number:</b>		
	<b>Physician Signature:</b>		
	<b>Start Date:</b>	____/____/____	<b>Date to Discontinue:</b> <small>(1 year maximum)</small>

<b>PARENT / GUARDIAN AUTHORIZATION</b>	I hereby request and grant permission for NewHope Academy personnel to administer medication to my daughter/son according to the instructions from the physician given above. I understand that administration by school personnel may be performed by an individual other than a certificated and/or registered nurse, and I specifically consent to this. I further waive any claims against NewHope, its staff, and agents arising out of the administration or self-administration of said medication, and agree to hold harmless and indemnify NewHope, its staff and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes or action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self-administration of medication.		
	_____ <b>Parent/Legal Guardian Signature</b>		____/____/____ <b>Date</b>
	_____ <b>Parent/Legal Guardian (please print)</b>		_____ <b>Daytime Phone Number</b>

- All medications are administered following these guidelines:**
- Physician/Prescriber signed/dated authorization to administer medication.
  - Parent signed/dated authorization to administer medication.
  - The prescription is in the original labeled container as dispensed or the manufacturer's labeled container. (OTC will be provided by NewHope.)
  - The prescription label contains the student name, name of the medication, and directions for use and date.
  - Annual renewal of authorization and immediate notification, in writing, of changes.