

ST. JOHN'S EPISCOPAL SCHOOL
3427 Olney Laytonsville Road, Olney, MD 20832
301-774-6408 Fax 301-774-2375

**AUTHORIZATION TO ADMINISTER
PRESCRIPTION MEDICATION**
Release and Indemnification Agreement

PART 1 TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize St. John's Episcopal School personnel to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify and hold harmless St. John's Episcopal School and any of their officers, staff members, or members, or agents from lawsuit, claim, demand, or action etc. against them, for administering prescribed medication to this student, provided St. John's follows the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

Student: _____ **Birthday:** ____/____/____ **Grade:** _____ **Teacher:** _____

Prescription: _____ **Renewal** _____ If new, the first full day's dosage was given at home on ____/____/____

List all medication/s student is taking (including over the counter medication/s): _____

Parent/Guardian Signature () _____ Phone _____ Date ____/____/____

PART II TO BE COMPLETED BY THE PHYSICIAN

St. John's Episcopal School discourages the administration of medication to pupils in school during the school day. Any necessary medication, which possibly can be administered before or after school, should be prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medications to pupils during the school day according to the procedures outlined on the back of this form.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ **Diagnosis:** _____
Trade name and/or generic

Dosage: _____ **Time(s) to be GIVEN AT SCHOOL:** _____

Route of Administration: _____ **Effective Dates: From** ____/____/____ **To** ____/____/____

Side Effects: _____

If PRN: Specify when indicated: _____

Frequency of administration: _____

Physician's name (print/type) () _____ *Phone*

Physician's signature _____ *Date* ____/____/____

PART II TO BE COMPLETED BY THE SCHOOL NURSE OR AUTHORIZED SCHOOL PERSONNEL

Check as appropriate:

- Part I to and II are completed including signatures. (It is acceptable if all items of information in Part II are written on the physician's stationary/prescription blank.)
- Prescription medication is properly labeled by a pharmacist.
- Medication label and physician order are consistent.

_____/_____/____ Date any unused medication is to be collected by the parent (within one week after expiration of physician's order.)

School Nurse Signature _____ *Date* ____/____/____