



ATHENS BIBLE SCHOOL

Student Medication Information

507 Hoffman Street Athens, AL 35611 256-232-3525 Fax: 256-232-5417

"A Better Education on a Better Foundation"

STUDENT INFORMATION

Student's Name _____
School _____ Grade _____ Teacher _____ School Year ____ - ____
List any known drug allergies/reactions _____ Height (inches) _____ Weight (lbs) _____

PRESCRIBER AUTHORIZATION

Name of Medication _____ Reason for Taking _____
Dosage _____ Route _____ Frequency/Time(s) to Be Given _____
Begin Medication _____ Stop Medication _____
Date _____ Date _____

Special Instructions:

Does medication require refrigeration? Yes No
Is the medication a controlled substance? Yes No
Is self-medication permitted and recommended for this student? Yes No
I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication(s)
If asthma inhaler or emergency medication, do you recommend this medication be kept **"on person"** by the student? Yes No

Potential Side Effects/Contraindications/Adverse Reactions _____

Treatment order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary)

Signature of Prescriber Date Phone Fax

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the principal, his/her designee, or the school nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

Signature of Parent or Guardian Date Phone

SELF MEDICATION AUTHORIZATION

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent or Guardian Date

If any questions or problems arise, call me at: (H) _____ (W) _____ (Cell) _____