The Cove School Student Medical Authorization Form

If a student requires medication during school hours, The Cove School must have authorization requests from their physician, physician assistant, or advanced practice RN, as well as the student’s parent/guardian, on file in the student’s school health record. Please have these requests completed and returned to the school. **The school must be notified in writing of any changes made to the medication. This form must be renewed at the beginning of each school year. This form must also be completed for the administration of Advil, Tylenol and other over the counter medication.**

**Parent Authorization**

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize The Cove School and its employees and agents, on my behalf and stead, to administer or attempt to administer to my child or to allow my child to self-administer while under the supervision of an employee or agent of the school, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and I specifically consent to such practices. I further acknowledge and agree that when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against the school, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school’s employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

The Cove School has my permission in the event of an emergency, when I cannot be reached, to seek medical intervention for my child at the nearest hospital or emergency room, and the hospital and its medical staff has my authorization to provide treatment that a physician deems necessary for the well being of my child. All emergency and hospital personnel have my authorization to provide proper immediate care for the well being of my child. The original of this document will be filed in the school office and taken with the student to the hospital if deemed necessary.

**Parent/Guardian Signature** ___________________________ **Date** ______________

**Parent’s/Guardian’s Phone Number** ______________________ **Parent’s/Guardian’s Emergency Phone Number** ______________________

Additional Information: ____________________________________________________________________________

**Parent Authorization**

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**Parent/Guardian Signature** ___________________________ **Date** ______________

**Parent’s/Guardian’s Phone Number** ______________________ **Parent’s/Guardian’s Emergency Phone Number** ______________________

Additional Information: ____________________________________________________________________________

**Parent Authorization**

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The Cove School has my permission in the event of an emergency, when I cannot be reached, to seek medical intervention for my child at the nearest hospital or emergency room, and the hospital and its medical staff has my authorization to provide treatment that a physician deems necessary for the well being of my child. All emergency and hospital personnel have my authorization to provide proper immediate care for the well being of my child. The original of this document will be filed in the school office and taken with the student to the hospital if deemed necessary.

**Parent/Guardian Signature** ___________________________ **Date** ______________

**Parent’s/Guardian’s Phone Number** ______________________ **Parent’s/Guardian’s Emergency Phone Number** ______________________

Additional Information: ____________________________________________________________________________

**Parent Authorization**

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize The Cove School and its employees and agents, on my behalf and stead, to administer or attempt to administer to my child or to allow my child to self-administer while under the supervision of an employee or agent of the school, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and I specifically consent to such practices. I further acknowledge and agree that when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against the school, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school’s employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

The Cove School has my permission in the event of an emergency, when I cannot be reached, to seek medical intervention for my child at the nearest hospital or emergency room, and the hospital and its medical staff has my authorization to provide treatment that a physician deems necessary for the well being of my child. All emergency and hospital personnel have my authorization to provide proper immediate care for the well being of my child. The original of this document will be filed in the school office and taken with the student to the hospital if deemed necessary.

**Parent/Guardian Signature** ___________________________ **Date** ______________

**Parent’s/Guardian’s Phone Number** ______________________ **Parent’s/Guardian’s Emergency Phone Number** ______________________

Additional Information: ____________________________________________________________________________
The Cove School Authorization for Student Self-Medication Form

(Required if student has authorization to self-administer asthma medication and/or an Epinephrine Auto-Injector)

School Year: __________________________  Student Birth Date: __________________________

Student’s Name: ____________________________________________________________________

**Physician, Physician Assistant or Advanced Practice RN Authorization:**

I certify that this student has been instructed in the use and self-administration of their emergency asthma medication and/or Epinephrine auto-injector (or EpiPen). He/She understands the need for the medication and/or any unusual side effects. He/She has been given instructions and is capable of using this medication independently.

1. Will this student self carry medication? ______ Yes ______ No
2. Will a second set of medication be kept in the health office at school? _____ Yes _____ No

_____________________________________________            ____________________________
Prescriber’s Signature                              Date Signed

__________________________________________________
Prescriber’s Emergency Phone Number

__________________________________________________
Prescriber’s Address

**Parent Authorization:**

I hereby authorize my son/daughter, to self administer the above referenced medication at school, school-sponsored activities, while under the supervision of school personnel, and before/after normal school activities such as before/after school care on school operated property. (We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his/her medication.)

I agree to indemnify and hold harmless The Cove School, its Board of Education and the Board members, officers, and volunteers from any claim, liability, loss or expense including reasonable attorneys’ fees, suffered by any of the foregoing and arising out of a claim related directly or indirectly to my son/daughter’s self-administration of the above referenced medication or brought by me, any other parent or guardian of my student or another student, or by or on behalf of my student or another student. We understand that the School and foregoing individuals are to incur no liability as a result of any injury arising from the self-administration of medication, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing.

Parent/Guardian Signature ___________________________            Date ____________

*Attach prescription label here:

**Student Authorization**

I agree to:

• Demonstrate correct use of the inhaler or Epinephrine auto-injector using a trainer/demonstrator to the registered nurse at school.
• Never share the inhaler or Epinephrine auto-injector with another person.
• Notify a teacher or other responsible adult if there is not marked improvement in my breathing within several minutes after two puffs of the inhaler.
• Immediately notify a teacher or another responsible adult if I use my Epinephrine auto-injector.

Student Signature: ___________________________            Date: ______________

PL 6/25/18
The Cove School Student Medical Authorization Form

When a student must take medication during school hours, the Cove School must have requests from the Physician, Physician Assistant, or Advanced Practice RN and the student’s parent/guardian on file in the student’s school health record. Please have these requests completed and returned to the school. The school must be notified in writing of any change in medication. This form must be renewed at the beginning of each school year. This form must also be completed for the administration of Advil, Tylenol and other over the counter medication.

_________________________         __________________
Student’s Name         Birth Date

School medications and health care services are administered following these guidelines:
- Medical Practitioner/prescriber signed and dated authorization to administer the medication
- Parent/guardian signed and dated authorization to administer medication
- The medication must be in the original labeled container as dispensed or the manufacturer’s labeled container
- The medication label must contain the student’s name, name of the medication, directions for use and date
- Annual renewal of authorization and immediate notification of changes is required

Must be completed by prescribing medical practitioner

Medication/Treatment         Dosage         Time to be administered

Intended effect of medication/Treatment: ____________________________________________________________

Side effects (if any): ______________________________________________________

Name of condition for which medication is prescribed: ______________________________________

Administration Instructions: ________________________________________________________________

Other medication the student is taking (at home or school): ______________________________________

Period of time medication is to be administered: From (Date) ____________________________ To (Date) ____________________________

Special requirements (refrigeration of medication, medication to be given with food, etc.) ____________________________

May the student self-administer the medication under the supervision of a school nurse or school designee?   Yes   No

Date to discontinue, reevaluate or follow-up: __________________________________________

_________________________         __________________
Prescriber’s Signature         Prescriber’s Printed Name

Address         City         Telephone         Emergency Telephone

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Parent/Guardian Signature ____________________________ Date _____________

PL 6/27/16
Permission in the Event of an Emergency

The Cove School has my permission in the event of an emergency, when I cannot be reached, to seek medical intervention for my child at the nearest hospital or emergency room, and the hospital and its medical staff has my authorization to provide treatment that a physician deems necessary for the well being of my child. All emergency and hospital personnel have my authorization to provide proper immediate care for the well being of my child. The original of this document will be filed in the school office and taken with the student to the hospital if deemed necessary.

Parent/Guardian Signature _________________________________________ Date _____________

_________________________          ______________________________
Parent’s/Guardian’s Phone Number                        Parent’s/Guardian’s Emergency Phone Number

Additional Information:  ____________________________________________ PL 6/27/16