River Vale Educational Fund, Inc **Revised 8/10/10**

MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name _____ **Date of Birth** _____

School _____ **Grade** _____

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**

Prescribing Doctor _____

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 ☐

If yes, do you recommend this medication be kept by the student? Yes ☐ No ☐

Additional Instructions (concerns):

_____

_____

Potential Side Effects/Contradictions/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 *(please print)*	**Date**	**Phone**	**Fax**

PARENT AUTHORIZATION

I authorize the ACE Staff, 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 ACE Staff to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the ACE Staff. It must be in the original, unopened, sealed 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 expiration when appropriate.

_____	_____	_____	_____
Signature of Parent	**Date**	**Phone**	**Cell**

SELF-ADMINISTRATION 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	***DATE***	***PHONE***	***CELL***