THE COVE SCHOOL

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.**

_____ _____ _____ _____
Student's Name Birth Date Current Date Grade

Address: _____ Teacher: _____

Home Phone: _____ Emergency Phone: _____

Must be completed by prescribing medical practitioner

_____ _____ _____
Medication/Treatment Dosage Time to be administered or under what circumstance

Purpose, intended effect of medication/Treatment: _____

Side effects (if any): _____ Frequency _____

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: _____

_____ _____ _____
Medical Practitioner's Signature Medical Practitioner's Printed Name Date signed

_____ _____ _____ _____
Office Address City Office Telephone Emergency Telephone

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: _____

PL 6/25/18

THE COVE SCHOOL

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's/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

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 | 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 | Date signed

_____

Address | City | Telephone | Emergency Telephone

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.

Parent/Guardian Signature _____ Date _____

THE COVE SCHOOL

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