North Central Academy

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Name of Student _____ Birth date _____

Class _____ Teacher _____ Date received by BCA _____

Physician's Order: ***(to be completed by physician or authorized prescriber)***

Diagnosis/Purpose of Medication
_____/_____

Name of Medication _____ **Dosage** _____

☐ **Tablet/capsule** ☐ **Liquid** ☐ **Inhaler** ☐ **Injection** ☐ **Nebulizer** ☐ **Other** _____

Frequency _____ **Time of Day** _____ **Anticipated Duration** _____

This prescription is: _____ **Initiation of Therapy** _____ **Adjustment of Dosage**
_____ **Maintenance Dose** _____ **Discontinuation of Therapy**

Important side effects or restrictions: _____

Start: ☐ **date form received** ☐ **other dates:** _____
Stop: ☐ **end of school year** ☐ **other date/duration:** _____
☐ **for episodic/emergency events only**

Special storage requirements: ☐ **None** ☐ **Refrigerate** ☐ **Other**_____

Physician's Signature _____ **Phone** _____ **Date** _____

Physician's Name _____ **Address**_____

The undersigned parents/guardian authorizes Bay City Academy, through its office staff, building level principal/secretary, to administer medication or to supervise the taking of medication by my child.

It is understood that the undersigned parents/guardian shall immediately notify the school district in writing in the event the prescription shall be discontinued or modified.

The medication must be brought to school by a parent/guardian in the original pharmacy bottle, appropriately labeled. The medicine must be kept locked in the school office. Refill of the prescription shall be the responsibility of the parents/guardians.

Further, the undersigned release the school district and shall indemnify said school district from any liability or damage which may result to the student from the administration of said medicine as prescribed by the physician.

Parent/Guardian Signature _____ Date _____

Home Phone _____ Daytime Phone _____