BRIGHTON AREA SCHOOLS
AUTHORIZATION FOR ADMINISTERING MEDICATION

The Brighton Area School District requires all students receiving any medication during schools hours, whether prescription, over-the-counter or homeopathic, to have the following information: (1) written instructions signed by the physician and "permission form" signed by the parent/guardian; (2) ALL medication must be in the **original prescription bottle** and properly labeled; (3) prescribed over the counter medication must be in the manufacturer's container; (4) ALL medication must be provided by the parent and kept in the school office unless the physician has designated that the student may carry the medication; and (5) parents must deliver all medication to school unless the physician's order specifies that the student is to carry the medication.

School _____
Student _____Grade_____ D.O.B. _____

PHYSICIAN'S STATEMENT – To be completed by physician:

Name/Type of medication:_____

Reason for medication (Optional) _____

Form of medication/treatment: (Please check appropriate form of treatment)

Tablet/Capsule___ Liquid___ Inhaler/Nebulizer___ Topical ___ Injection _____ Other_____

Schedule and Dosage to be given at school: _____

Start Date:_____ Stop Date:_____
Restrictions and/or important side effects: None Anticipated ___ If anticipated, please describe_____
_____

Is the child allergic to any medication: Yes _____ No _____ If yes, what medication _____

This student may carry their inhaler and is capable of self administration: Yes_____ No_____
(Students are not allowed to possess controlled substances at school)

Physician's Signature_____ Date _____

Address_____
_____

Please send an EPIPEN that will not expire during the school year.

Phone #_____

PARENT PERMISSION

School policy prohibits students from possessing any type of medication in school, including over-the-counter medication unless prescribed by a physician.

I give my permission for my child to receive the above named medication at school. I understand that the medication will be administered to my child by the authorized staff person (i.e. secretary, principal, school nurse, or other designated individual). *I understand that the use of self possessed and self administered medication (i.e. inhalers) will NOT be supervised or monitored by school personnel.* I agree that you may contact the physician who prescribed the medication and I hereby authorize her/him to release to you any information concerning my child's condition and treatment related to the use of this medication. Further, I understand and agree that I will not send medication to school with my child but will deliver it myself.

_____ _____
Parent/Guardian Signature **Date**

Home Address _____

Home Phone #_____ Work Phone #_____