Parental Consent and Licensed Prescriber Authorization for Administering Prescription Medication

Instructions: Complete a separate form for each prescription medication. The Parent/Guardian must complete the top box, and the physician must complete the bottom box.

THIS FORM MUST HAVE A DOCTOR'S SIGNATURE

To Be Completed By Parent/Guardian

Student Name: ____Date of Birth:_____ / _____ /_____

Allergies:____

I am the parent or guardian of __________________________. I give my permission for appropriately trained Northstar Academy and/or Career Center staff to administer the following medications to him/her during school hours. I herby acknowledge that I have read, understand, and will abide by Northstar's Student-Parent Handbook procedures relating to the transportation/handling of medications at school. I hereby release Northstar and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of Northstar to share information regarding this medication with the licensed prescriber below.

_________________________________ _____________________ _____________

Parent/Guardian Signature Daytime Phone Date

Medication Authorization

(For Use by Licensed Prescriber ONLY)

Relevant Diagnosis: _____________________________ Medication/Strength: ______________________

Dose: __________ Route: __________ Frequency: ____

Duration of Administration:

Short term (List dates to be given): ____________________

For the duration of the current school year

A. Serious reactions can occur if the medication is not given as prescribed:

☐ YES ☐ NO *If yes, describe:* ____

B. Serious reactions/adverse side effects from this medication may occur:

☐ YES ☐ NO *If yes, describe:* ____

Action/Treatment for reactions: ____

Report to you: ☐ YES ☐ NO *(Attach Drug Information Sheet If Desired)*

Special Handling Instructions: ☐ Refrigerate ☐ Keep out of sunlight ☐ Other:______________________

Asthma/Diabetes/Allergy Rescue Medications ONLY

This student is BOTH capable of and responsible for self-administering this medication:

☐ YES- Supervised ☐ YES- Unsupervised ☐ NO

This student may carry this medication: ☐ YES ☐ NO

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Licensed Prescriber Name (Please Print)

______________________________ _______

Licensed Prescriber Signature Date

Licensed Prescriber Address/Phone:

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