Riverdale Baptist School

2017-2018

Combined Medication Administration Authorization

This form is optional but required to administer medication.

Student_____ Entering Grade:_____
Last First Middle

Birth date: ____/_____/_____ Sex: M F Related Allergies:_____

Current Medications: _____

I authorize the administration of the following medications by a designated Health Professional whenever necessary or emergency medication may be self-administered as authorized by the physician under staff supervision. Prescription medications are supplied exclusively by the parent and must have **a pharmacy label that exactly matches** the information specified in the space provided below. I understand that at the end of the authorized period, an adult must pick-up the medication, otherwise it will be discarded. The administration of over-the-counter (OTC) medications will be according to the manufacturer's packaged instructions. I authorize school personnel to communicate with the prescriber as allowed by HIPPA. As with any medication, I understand there are adverse effects for which the Health Professional is not liable. ***This form is good for the 2017-2018 school year and will expire on June 9, 2018.***

_____ _____
Parent/Guardian Signature *Date*

Required to be completed by PHYSICIAN or Nurse Practitioner:

_____ *Physician Initials*

STANDING ORDERS: (to be given according to the manufacturer's package instructions)

Tylenol (acetaminophen)	Sugar-Free Cough Drops	Tums
Ibuprofen	Chloraseptic Menthol Lozenges	Hydrocortisone Cream
Benadryl	Gas-X (simethicone)	

_____ *Physician Initials*

EMERGENCY inhaler/nebulizer*:
Please give 2 puffs or 1 vial of albuterol / xopenex every___ hours PRN
for asthma symptoms of ☐**coughing** ☐**wheezing** ☐**other:**_____
Transport: ☐**may** ☐**may not** be self-administered AND ☐**may** ☐**may not** be self-carried.
*Inhaler & nebulizer are interchangeable unless otherwise indicated.

_____ *Physician Initials*

EMERGENCY epinephrine auto injector
Dose: ☐ 0.15mg ☐ 0.3mg *Brand:* ☐ Epipen or ☐ Auvi-Q
Transport: ☐**may** ☐**may not** be self-administered AND ☐**may** ☐**may not** be self-carried.
Reason for medication and administration: (management of acute allergic reactions)
____ a. Exposure to Allergen: _____
____ b. **Anaphylaxis** or listed symptoms: _____
Route: Autoinjection into anteriolateral aspect of the thigh
Side Effects: rapid heart rate, _____
Follow Up: 911 WILL BE CALLED IMMEDIATELY

I authorize the administration of medications as initialed above. There are no known allergies, current medications, or health conditions that interfere with the safe administration of these medications.

_____ _____
Physician/Prescriber's Signature *Date*

REQUIRED: *Prescriber's Address Stamp*

Parent/Guardian is responsible for any duplication of this form. Updated June 2015