Dispensing Medicine Authorization Form

Student Name_____Grade_____School Year_____

This form must be completed fully and turned into the school office BEFORE any medication will be administered. A new **Dispensing Medicine Authorization Form** must be completed and signed by the parent/guardian and physician 1) at the beginning of each school year, 2) for each medication, 3) any time there is a change in the prescription of medication, and 4) overnight field trips requiring medication.

MUST BE COMPLETED AND SIGNED BY PHYSICIAN

PHYSICIAN'S ORDER for **1)** Prescription Medication or **2)** Long-Term Use (>2 weeks) of OTC Medication 3) Asthma in halers that are NOT self-carry/self –administer must provide ASTHMA ACTION PLAN

Medication Name of Medication_____

Dosage_____Frequency_____Route_____

Physician's note to the school's office regarding this medication/diagnosis_____

(Physician's signature below confirms necessity of medication administration during the school day.)

Physician's Name (printed)_____

Telephone_____Fax_____

Address_____

Physician's Signature_____

Date_____

(Use for Physician's Address Stamp)

TO BE COMPLETED BY PARENT/GUARDIAN, AS NEEDED

ASTHMA INHALER SELF CARRY AUTHORIZATION: TOCA will permit students to self-carry and self-administer asthma inhalers in a prescription labeled box during the school day, field trip or school sponsored event **ONLY with parent/guardian initials agreeing** to ALL of the following:

_____I give permission for this student to self-carry and self-administer his/her asthma inhaler.

_____I have provided TOCA with a copy of the prescription label on the asthma inhaler box.

_____I agree to take full responsibility for the risks and consequences to my student if I do not provide the school's office or field trip chaperone with an **additional** prescribed asthma inhaler.

LIFE-THREATENING ALLERGY TREATMENT MEDICATION: If the above physician-prescribed medication is to treat an allergic reaction, **parent/guardian must initial**, agreeing to:

_____I have provided Trinity Oaks with the **Illinois Food Allergy Emergency Action Plan and Treatment Authorization** form that has been fully completed and signed by my student's physician, along with all prescribed rescue medications.

Please review and complete side 2 →

Administration of medication by Trinity Oaks Christian Academy personnel is contingent upon the following guidelines:

1. The PHYSICIAN'S ORDER must be fully completed, signed by the parent/guardian and physician, and turned into Trinity Oaks BEFORE any medication will be administered to the student.
2. The medication must be brought to the school office in a pharmaceutical container labeled with the student's name, name of medication, the dosage, and all pertinent instructions. Students permitted self-carry/self-administer asthma inhalers must carry prescription labeled inhaler.
3. Trinity Oaks does not have a nurse; therefore medication will be administered by non-medical school personnel.
4. The school will maintain a written record of any medication dispensed, including the student's name, name of medication, date/time it was administered, and by whom.
5. This form is valid for one school year only. Forms must be renewed each school year, with parent and physician signatures.
6. Any change in prescription of this medication requires a new **Dispensing Medicine Authorization Form** (DMAF), complete with parent/guardian and physician signatures.
7. Overnight field trip medications require physician authorization, diagnosis, dosage and instructions to be provide to the school office 48 hours prior to departure. Students may self-carry/self-administer asthma inhaler if parent authorization and prescription labeled is on file with the office.

PARENT/GUARDIAN SIGNATURE REQUIRED

PARENT/GUARDIAN AUTHORIZATION

I hereby confirm that I have reviewed and understand Trinity Oaks Christian Academy policy regarding the administration of prescription and OTC medications. On my behalf, I authorize Trinity Oaks Christian Academy and its employees to administer or attempt to administer to my child this lawfully prescribed medication in the manner described on the Physician's Order. I certify that I have legal authority to consent to medical treatment for the student named within this document, including the administration of medication at school. In addition, I agree to hold harmless and indemnify the school and its employees from and against any and all claims, damages, and causes of action or injuries incurred or resulting from the administration or attempt to administer said medication. I agree and specifically authorize school administration to provide health information about this student to school employee's or approved parent chaperone's, if in the school's discretion there is a need for them to know this information, to provide a safer environment for the student.

Parent/Guardian Signature_____Date_____

OFFICE USE ONLY

Order reviewed by school:

Signature_____Date_____

Notes_____

Asthma Action Plan on file _____ Asthma Self-Carry/declined providing extra inhaler_____