BEAUMONT SCHOOL

• A Catholic School in the Ursuline tradition educates women for life, leadership and service •

PHYSICIAN AUTHORIZATION AND PARENTAL REQUEST FOR ALL MEDICATIONS

_____ _____ _____

Student's Name Grade or Homeroom Date of Birth

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for medication: _____

Name of medication: _____

Medication form: ___tablet/capsule ___liquid ___inhaler ___injection ___other:_____

Special Storage Requirements: ___refrigerate ___none ___other: _____

Start date: _____Stop Date: ___end of school year ___other/duration ____for episodic/emergency events only

Instructions (schedule and dosage to be given) _____

_____

Restrictions/side effects _____

Adverse reactions that should be reported to the physician _____

If prescribing and **EPIPEN** or **RESCUE INHALER**, is student capable and responsible for self-administering this medication? ___No ___Yes (supervised) ___Yes (unsupervised)

May the student carry the **Epipen** or **Rescue Inhaler**? ___Yes ___No

Procedure to follow in event medication does not produce expected relief _____

_____

Date: _____Signature: _____
Authorized prescriber

Physician's name printed: _____

Address: _____
Phone number: _____Emergency number: _____

Date:
Reviewed by Nurse:

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, _____to receive the above medication at school or field trips according to Beaumont School policy. It is understood that Beaumont School and all of its personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand the medication must be brought to school in its original container or the container to which it was dispensed from the pharmacist.

Date: _____Signature of Parent/Guardian: _____

Address: _____Phone number: _____