**THE WATSON INSTITUTE FRIENDSHIP ACADEMY**
**CONSENT FOR ADMINISTRATION OF MEDICATION AND MEDICAL ORDER**

Your patient has requested that a PRESCRIPTION or an OVER THE COUNTER (OTC) MEDICATION be taken at school. Most medications should be taken at home unless there is a specific lunchtime dose or the medication is an emergency or PRN medication like Asthma or migraine medications.

**ALL MEDICATIONS TAKEN AT SCHOOL MUST HAVE PARENTAL CONSENT FOR ADMINISTRATION, A MEDICAL ORDER AND BE IN THE ORIGINAL PHARMACY LABELED CONTAINER. A PHOTO OF THE STUDENT WILL BE TAKEN AND ATTACHED TO THE STUDENT'S MEDICATION LOG.**

*****TO BE COMPLETED BY PARENT***PLEASE PRINT CLEARLY**

Student Name:_____ Birthdate:_____ Grade:_____

I understand fully the directions that have been given to the school by the physician and agree to permit the school to administer the medication as directed or to monitor the self-administration of the medication by my child. In consideration of Friendship Academy's good faith efforts to follow the physician's instructions, Friendship Academy is hereby relieved from any liability for any failure to properly administer or to monitor the self-administration of medication.

I hereby authorize Friendship Academy Health Staff to contact the medical provider below regarding this medication to release information regarding my child (named above) to said provider. I hereby authorize the medical provider to release information about my child and this medication to Friendship Academy Health Staff regarding any medical concerns about this medication order.

I understand that in order to protect the limited confidentiality of medical information, my agreement to release information is necessary and that this permission is limited for the purpose and to the person or entity listed above, and will be effective for one year. I understand that the disclosed information will be kept confidential and the releasing facility will not be responsible for re-disclosure of the information. I also understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

| Parent/Guardian Signature | Parent/Guardian Print Name | Date |
|---|---|---|

| Phone Number | Alternate Phone Number |
|---|---|

*****TO BE COMPLETED BY PHYSICIAN***PLEASE PRINT CLEARLY**

| Diagnosis: | Length of treatment: |
|---|---|
| Medication: | |
| Dose, Route, Schedule: | |
| PRN (indications and timing) | |
| List of serious reactions to the medication: | |
| List appropriate response to above reactions: | |

| Physician's Signature | Print Name: | Date |
|---|---|---|

Address and Zip Code

| Phone Number | Fax Number |
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