Liberty Baptist Academy

Fax: (772) 461-2542

3660 West Midway Road, Fort Pierce, FL 34981 (772) 461-2731

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Top portion to be completed by physician. Bottom to be completed by parent/guardian.
Please return completed form and medication to the school office. This form is void if altered in any way.

[redacted]

This request is to be effective for the school year _____ or earlier stop date: _____

Student's Name: _____ DOB: _____

Medication or generic name:_____
Dosage Amount: _____ Time to be administered at school: _____
Condition for which the drug is to be given: _____
Note any untoward side effects: _____

INHALENT PRESCRIPTIONS:

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

❑ No ❑ Yes – Supervised ❑ Yes – Unsupervised

EPINEPHRINE AUTO-INJECTOR PRESCRIPTIONS:

❑ This student is both capable and responsible for self-administering this medication
❑ Trained school staff should assist to administer this medication.

The epinephrine should be administered under the following "specific" conditions:

- ❑ Immediately post exposure to the allergen
- ❑ Only if the following reactions occur (please check all that apply):
  - ❑ Shortness of breath/wheezing ❑ Hives/rash
  - ❑ Generalized swelling/edema ❑ Other _____

Physician/Legal Prescriber's Signature: _____ Date:_____

Name (please print): _____ Telephone:_____

Address: _____

[redacted]

I request the designated school personnel to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication at school. I understand that: (1) there is no liability on the part of Liberty Baptist Academy, its personnel, or agents for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication should be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, whichever occurs first. Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication, or any change in medication requires a new form. The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired.

Parent/Guardian Signature: _____ Date: _____

Name (please print): _____ Telephone: _____