ALPHA ACADEMY
PHYSICIAN'S SCHOOL MEDICATION FORM

Rev. 05/2023

TO BE COMPLETED BY MEDICAL PROVIDER

Student's Name: _____ Date of Birth: _____

Name of School: _____ Grade: _____

The above named person is a patient currently under my medical care. Due to a medical condition the medication listed below must be (given/taken/injected) during regular school hours according to the following protocol:

Medication: _____ Dose: _____ Route: _____

Dose must be exact; ranges will not be accepted.

☐ Routine/Daily Medications: exact time to be given _____ a.m. _____ p.m.

☐ As needed (p.r.n.) medication for: _____ give every _____ hour(s).

Directions for administering medication: _____

_____

Please indicate any special storage requirements such as room temperature, refrigeration, etc. _____

_____

MD Stamp Below

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Office Phone: _____ FAX: _____

Office Address: _____

City, State, ZIP: _____

This order will expire one year from the date the physician signed.

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I understand that:

- prescription medications may be administered at school and must be in a pharmacy-labeled prescription bottle that matches the Alpha Academy Physician's School Medication Form. Medication dosage, time and intervals, must be exact.
- the school nurse is available one day a week.
- non-medical personnel administer medications daily.
- prior to school administration, the parent/guardian is required to sign the check-in/check-out log for medication.
- students are not permitted to transport medication to or from school.
- medication may only be administered as ordered on the approved Alpha Academy medication forms.
- if medication is not available at the school, 911 will be called for emergencies.
- the parent/guardian is responsible for notifying coaches or supervising staff of before and/or after-school activities of the child's health status and/or the need for medication.
- I may contact the Primary Medication Clerk or school nurse if assistance is needed to ensure medication meets Alpha Academy's Protocol for Medication Administration.
- **medication not picked up within two weeks of the last day of school will be discarded.**

I, _____ the parent/legal guardian of _____ enrolled at _____ school realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, Alpha Academy , and the Alpha Academy Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

Parent/Legal Guardian's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

FOR OFFICE USE ONLY: This order will expire one year from the date the physician signed. This form will expire on _____

DISPOSITION OF MEDICATION: Date medication was picked up _____ or date medication was discarded _____

by Staff Name: Staff Signature: Witness: