

TheCaedmonSchool

MEDICATION ADMINISTRATION FORM (MAF): FAMILY'S CONSENT, AUTHORIZATION, AND RELEASE

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary means of administration of such medication, in accordance with the attached instructions of my child's physician. I understand that the medication is to be furnished by me in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container.

Student's Name: _____ Licensed Prescriber's Name: _____

Name of Medication: _____ Licensed Prescriber's Phone Number: _____

Dosage: _____

Time: _____

By submitting this MAF, I am requesting that my child be provided with specific health services by The Caedmon School (the "School"). I have provided the full and complete information and instructions regarding the provision of the above-requested health service(s) in this MAF. I understand that the School and its employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information and instructions that I have provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that I have provided in this MAF. I understand that it is my responsibility to provide the medication that has been prescribed for my child. I further understand that the School and its employees are not responsible for any adverse reaction to this medication.

I further understand that I must immediately advise the School's health director and/or his/her designee(s) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I recognize that this form is not an agreement by the School to provide the services requested, but, rather, my request, consent, authorization and release for such services.

I hereby authorize the School and its employees to consult with and to obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

Please Print Family Member's Name & Address Below:

Family Member's Signature

Date Signed

Relation to Student

Daytime Telephone No.