ATHENS BIBLE SCHOOL
Student Prescription Form

507 Hoffman Street Athens, AL 35611 256-232-3525 Fax: 256-232-5417 www.athensbibleschool.org

"A Better Education on a Better Foundation"

This form is to be used on a case by case basis and is only required if and/or when your child needs to take prescribed medication during the school day. This must be signed by the prescriber.

STUDENT INFORMATION

Student's Name_____ DOB_____

School _____ Grade _____ Teacher _____ School Year_____-_____

Height (inches) _____ Weight (lbs)_____ List any known drug allergies/reactions _____

_____

PRESCRIBER AUTHORIZATION

Name of medication _____ Reason for taking _____

Dosage _____ Route _____ Frequency/Time(s) to be given _____

Begin medication (date) _____-_____-_____ End medication (date) _____-_____-_____

SPECIAL INSTRUCTIONS

Does the medication require refrigeration: Yes ❑ No ❑

Is the medication a controlled substance: Yes ❑ No ❑

Is self-medication permitted and recommended for this student: Yes ❑ No ❑

If you marked "yes", then please sign the "Self-Medication Authorization" area below.

Potential side effects/contraindications/adverse reactions _____

_____

Treatment order in the event of an adverse reaction (attach additional sheet or use the back of this form if necessary).

_____

_____

_____	_____-_____-_____	_____	_____
Prescriber	**Date**	**Phone**	**Fax**

PARENT AUTHORIZATION

I authorize the School Nurse, the Registered Nurse (RN) or Licensed Practical Nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of the medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the principal, his/her designee, or the school nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug's expiration when appropriate.

_____	_____-_____-_____	_____
Signature of Parent or Guardian	**Date**	**Phone**

SELF-MEDICATION AUTHORIZATION

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the agents of the school and the local school board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

_____	_____
Signature of Parent or Guardian	**Date**

If there are any problems or questions please call me at: _____ _____ _____

(Home) (Cell) (Work)