Stone Ridge
School of the Sacred Heart

Stone Ridge School of the Sacred Heart
9101 Rockville Pike
Bethesda, Maryland 20814

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION
Release and Indemnification Agreement

PART I – TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Stone Ridge personnel to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless Stone Ridge and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided Stone Ridge staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

Student:_____ Birth date:__/__/__School:_____

Prescription: ☐ Renewal ☐ New If new, the first full day's dosage was given at home on:___/___/____

List all medication(s) student is taking, including over-the-counter medication(s):_____

_____

_____ _____-_____-_____ _____/____/_____
Parent/Guardian Signature *Phone Number* *Date*

PART II – TO BE COMPLETED BY THE PHYSICIAN

Stone Ridge discourages the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before and after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the back of this form.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication:_____ Diagnosis:_____
Trade name and/or generic

Dosage:_____Time(s) To Be Given At School:_____

Route of Administration:_____ Effective Dates: From____/____/___ To____/____/____

Side Effects:

If PRN, specify:

When indicated (signs/symptoms)_____

Frequency of administration_____

_____ _____ _____-_____-_____ _____/___/___
Physician's Name (print/type) *Physician Signature* *Phone Number* *Date*

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication such as inhalers and EpiPens® **must** be authorized by the prescriber and be approved by the school nurse according to the State medication policy:

Prescriber's authorization for self-carry/self-administration of emergency medication_____ ____/___/____
Signature *Date*

School RN approval for self-carry/self-administration of emergency medication_____ ____/___/____
Signature *Date*

PART III – TO BE COMPLETED BY THE SCHOOL NURSE

Check as appropriate:

☐ Parts I and II above are completed, including Signature. (It is acceptable if all items of information in Part II are written on the physician's stationary/prescription blank.)

☐ Prescription medication is properly labeled by a pharmacist.

☐ Medication label and physician order are consistent.

☐ Over-the-counter medication is in an original container with the manufacturer's dosage label and safety seal intact.

_____/____/____ Date any unused medication is to be collected by the parent or guardian (within one week after expiration of the physician's order).

_____ _____/____/_____
School Nurse Signature *Date*