

BROOKLYN FRIENDS SCHOOL
375 Pearl Street, Brooklyn, NY 11201
SELF-MEDICATION RELEASE FORM

(T) 718-852-1029 x 241
(F) 718-643-4868

Name _____ Age _____
Date of Birth _____
Grade _____ Classroom _____
Teacher/Advisor _____

TO BE FILLED OUT BY PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER:

Name of medication _____
Condition for which medication is needed _____
Dose _____ Route of administration _____
Time or indication of administration _____
Is this a controlled drug? _____yes _____no
Dates of administration (limit of one school year) _____
Side effects to be noted/reported _____
Other recommendations _____

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Physician Signature _____ Print Name _____
Date _____ Phone _____

TO BE FILLED OUT BY PARENT/GUARDIAN:

I request that my child, named above, be permitted to carry on his/her person and self-administer the medication(s) prescribed by the physician whose signature appears above. I take responsibility for giving my child this permission and will monitor the student's daily use. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and name of medication; date of original prescription, strength and dose of medication; and directions for use. I also understand that the number of pills to be carried is determined by the School Nurse. The student is responsible for carrying the medication at all times and will be denied access to class trips and participation in sports if he or she is not carrying it.

Parent/Guardian Name _____ Phone(s) _____
Signature _____ Date _____

TO BE FILLED OUT BY SCHOOL NURSE:

I have counseled the above student and determined that he/she may safely self-administer the requested medication. The student is aware of when and how to use the medication, and of any possible side effects. BFS accepts the parent request and physician statement. BFS reserves the right to withdraw the self medication privilege if the student shows signs of irresponsible behavior or there is a safety risk; we will contact the parents as soon as possible in this event. The student is responsible for carrying on his/her person the medication at all times and will be denied access to class trips and participation in sports if he/she is not carrying it.

Nurse's Signature _____ Date _____
Student Signature _____ Date _____