

BROOKLYN FRIENDS SCHOOL
SELF MEDICATION RELEASE FORM

Name of Student _____ Age _____ Date of Birth _____

Grade _____ Classroom Teacher/Advisory _____

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

Name of medication, dose, method administered, time or indication of administration _____

Condition for which medication is administered _____

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 _____

Telephone _____

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 to carry the medication at all times and will be denied access to class trips and participating 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 how to use the medication, and 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 to carry on his/her person the medication at all times and will be denied access to class trips and participating in sports if he/she is not carrying it.

Nurse's Signature _____ Date _____

Student Signature _____ Date _____