Carle Auditory Oral School/Carle Foundation Hospital Physician Authorization And Permission For Medication Administration

 Medication is administered following these guidelines: Physician/Prescriber signed, dated authorization to administer the medication Parent signed, dated authorization to administer the medication Medication is in the original labeled contained as dispensed (or the manufacturer's labeled container) 	Student's Name:		Today's Date:	
 Parent signed, dated authorization to administer the medication Medication is in the original labeled contained as dispensed (or the manufacturer's labeled container) PHYSICIAN AUTHORIZATION:	(Last)	(First)	Birth Date	
 Physician/Prescriber signed, dated authorization to administer the medication Parent signed, dated authorization to administer the medication Medication is in the original labeled contained as dispensed (or the manufacturer's labeled container) PHYSICIAN AUTHORIZATION:	Student attends the following days/times:			
PHYSICIAN AUTHORIZATION:	 Physician/Prescriber signed, dated authorization to a Parent signed, dated authorization to administer the 	medication		
	 Medication is in the original labeled contained as di 	pensed (or the manufacturer's labele	ed container)	
Medication: Dosage:	PHYSICIAN AUTHORIZATION:			
	Medication:		Dosage:	
Time to be administered: Intended effect of this medication:	Time to be administered:	Intended ef	Intended effect of this medication:	
Expected side effects, if any: Administration instructions:	Expected side effects, if any:	Administrat	Administration instructions:	
Other medications student is taking: Discontinue/Re-Evaluate/Follow-up Date (circle one):	Other medications student is taking:	Discontinue	Discontinue/Re-Evaluate/Follow-up Date (circle one):	
Physicians Signature: Date Signed:	Physicians Signature:	'	Date Signed:	
Physicians Name: Physician's Emergency Phone #:	Physicians Name:		Physician's Emergency Phone #:	
PARENT AUTHORIZATION AND PERMISSION FOR MEDICATION ADMINISTRATION I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event medical emergency, I hereby authorization Carle Auditory Oral School and its employees and agents, on my behalf, to administer or attempt to administer to my lawfully prescribed medication or over-the-counter medications that I have provided. These medications must be labeled appropriately as follows: • Prescription medication is administered in accordance with the pharmacy label directions as prescribed by the child's health care provider. Instructions from child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider. • Over the Counter medications may be administered in accordance with the product label directions on the container with physician authorization. The instructions from the child's parent/guardian shall not conflict with the product label directions on the container.	I herewith acknowledge that I am primarily responsible for medical emergency, I hereby authorization Carle Auditory lawfully prescribed medication or over-the-counter medic • Prescription medication is administered in accordant child's parent/guardian shall not conflict with the late. • Over the Counter medications may be administered.	r administering medication to my chil Oral School and its employees and ag ations that I have provided. These med ce with the pharmacy label directions a el directions as prescribed by the child in accordance with the product label d	gents, on my behalf, to administer or attempt to administer to my child dications must be labeled appropriately as follows: as prescribed by the child's health care provider. Instructions from the ld's health care provider. directions on the container with physician authorization. The instructior	
I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Carle Auditory Oral So Carle Foundation Hospital or its agents and employees arising out of the administration of said medication.				
Child's Name: Date Signed:	Child's Name:		Date Signed:	
Parent/Guardian Signature: Contact Phone #:	Parent/Guardian Signature:		Contact Phone #:	



