WILLOWS ACADEMY

Parental Authorization/ Request and Release
Regarding Willows Academy Administration of Student Medication During School Hours by School Personnel (complete and submit the following 4 pages)

Name of Student: _____

Date of Birth:_____

School of Attendance: _**WILLOWS ACADEMY**_____ **20-21 Grade Level**:_____

Authorizing Physician:_____

Physician's Phone:_____ Address:_____

Parent:

1. Medical treatment is the responsibility of the parent and the family physician. Medications are rarely given at school. The only exceptions involve special or serious problems where it is deemed necessary to give the medication.

2. Willows Academy does NOT have a school nurse on staff. Other school personnel may have to assume the responsibility of administering a medication; however, she cannot be expected to assume this responsibility unless it is absolutely necessary.

   CONSEQUENTLY, THE PARENT/GUARDIAN IS URGED, WITH THE HELP OF THE FAMILY PHYSICIAN, TO WORK OUT A SCHEDULE OF GIVING THE MEDICATION OUTSIDE OF SCHOOL HOURS AS MUCH AS POSSIBLE.

3. A Physician's Statement (attached) must be completed by the student's provider, clearly specifying the condition for which the medication is to be given, how it is be given, unit dosage and related information. Specific instructions should be included for the administration of the medication at school. Specific instructions should be included for emergency treatment of allergic reactions to the specified medication.

4. Medication orders must be renewed by the attending physician and a release signed by the parents at the beginning of each school year or upon any change in medication orders.

5. Medications without required authorization and following proper procedures will not be kept at school.

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6. All medication sent to the school must be in the original container and delivered by an ADULT, NOT THE STUDENT. Medications cannot be accepted or given if they are submitted in household container, envelopes, or baggies.

7. Administration of the Prescribed Medication: The school personnel are not responsible for giving missed or late "home" doses of medication. The school personnel are not responsible for tracking down a student to make sure she takes her medication. The student must go to the specified school personnel at the proper time to obtain her medication. The student is required to take her medication in the presence of the school personnel. Once the school hours have ended the school personnel will NOT be responsible for administering any medication.

As requested by the parent:
PRESCRIBED MEDICATION TO BE ADMINISTERED (must be supported by the Physician's Statement below):

_____

TIME TO ADMINISTER THE PRESCRIBED MEDICATION: _____

The following guidelines shall apply to the administration of a student's medication noted above:

- **Physician/Prescriber Statement with signed, dated authorization to administer the medication, detailing the name and purpose of the medication, the prescribed dosage, time for administration and any other special related information to the administration.**
- **Parent (Guardian) signed, dated and authorization for Willows Academy to administer the medication to the student.**
- **The medication is in the original labeled container as dispensed showing the prescriber's name/phone/etc.**
- **The medication label contains the student name, name of the medication, directions for use and date.**
- **Annual renewal of authorization and, if any changes in medication take place, there must be immediate notification and a NEW Physician's Statement submitted.**
- **The Willows Academy and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of the medication to the student.**
- **The Willows Academy and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result or any injury arising from the timeliness of the administration of the medication.**

I have read, affirm and agree to the information presented above.

Parent signature: _____ Date: _____

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For PARENTAL AUTHORIZATION ~ see page 2
PARENTAL AUTHORIZATION:

I, _____, hereby acknowledge that I am the parent and/or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize Willows Academy to administer to my daughter her lawfully prescribed medication noted above during the following: (1) while in school at the appointed time noted above; (2) while under the supervision of school personnel;

I further acknowledge and agree that Willows Academy and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from administering the prescribed medication noted above to my daughter. I further acknowledge and agree that, in absence of willful and wanton conduct on the part of Willows Academy and its employees and agents, I waive any claims that I might have against said parties arising out of administering the prescribed medication noted above to my child. In addition, I agree to indemnify and hold harmless Willows Academy and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from administering my child's prescribed medication as noted above.

1. Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____

Home/Mobile Phone: _____ Business Phone: _____

#2. Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____

Home/Mobile Phone: _____ Business Phone: _____

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PHYSICIAN'S STATEMENT: (To be completed by student's physician for School Administration of Prescription Medication)

Name of Student: _____

Date of Birth:_____

School of Attendance: _**WILLOWS ACADEMY**_____ 20-21 Grade Level:_____

Authorizing Physician:_____

Physician's Phone:_____ Address:_____

The above named student has the following condition(s):

_____

I, _____, am the Physician of record for the above-referenced student and hereby confirm that this student must take this prescribed medication during a school day in the presence of school personnel. The specific name of the medication, the method, amount and time schedules by which the medication is to be taken are set forth below.

Medication:

_____

Dose: _____

Method: _____

Frequency/Time:_____

Possible Side Effects/Allergic Reactions:

_____

I certify that the above named student has been instructed in the use of this medication. She understands the need for the medication, the need to take this medication in the presence of school personnel and the necessity to report to school personnel any unusual side effects.

Physician's Printed Name: _____

Phone: _____

Signature of Physician: _____ Date:_____