AUTHORIZATION FOR PRESCRIPTION MEDICATION

Atlantic Shores Christian Secondary Campus ~ 1217 North Centerville Turnpike ~ Chesapeake, VA 23320 ~ (757) 479-9598 ~ Fax: (757) 479-5311

Atlantic Shores Christian Elementary Campus ~ 1861 Kempsville Road~ Virginia Beach, VA 23464 ~ (757) 479-1125 ~ Fax: (757) 479-8742

The information below is to be completed by the licensed prescriber.

Student Name: _____ DOB: ___/___/___ Grade: ____ School Year: _____

Allergies: _____ Medical Conditions: _____

MEDICATION

Medication Name: _____

Dates medication must be administered at school: From _____ To _____

_____ Every day at school _____ Episodic/Emergency Events ONLY

Dosage (Amount) _____ Route _____ Form _____ Time (s) of Day _____

- Serious reactions can occur if the medication is not given as prescribed: _____ Yes _____ No

  If yes, please describe: _____

- Serious reactions/adverse side effects from this medication may occur: _____ Yes _____ No

  If yes, please describe: _____

Special Handling Instructions: _____ Refrigeration _____Keep out of sunlight

____ Other _____

*For Asthmatic, Diabetic and Anaphylactic reactions ONLY

*This student is both capable and responsible for self-administering this medication:

_____No _____Yes, with supervision _____Yes, without supervision

*This student may carry this medication with him/her during the school day: _____ No _____ Yes

PRESCRIBER INFORMATION

Prescriber's Name: _____ Group Name: _____

Office Phone: _____ Office Fax: _____

Licensed Prescriber's Signature: _____ Date: _____

PARENTAL CONSENT

I give permission for my child to take the above prescribed medication while at Atlantic Shores Christian School. I hereby acknowledge that I have read and understand the Parental Responsibility for Medication Administration at school in the Student-Parent handbook. I hereby release ASCS and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber. I understand that it may include the advanced first aid administration of the Epi-pen in the event of anaphylaxis (a life-threatening allergic reaction). In the event of a serious illness and/or injury, the rescue squad may be utilized and treatment and/or hospital care may be rendered by, under supervision and/or on the advice of appropriate medical personnel. In such event, I understand that employees of ASCS will make reasonable efforts to contact a parent, guardian, emergency contact physician and/or dentist as feasible under the circumstances.

Parent/ Guardian Signature _____ Date _____