COMMONWEALTH ACADEMY

Authorization for Medication Release and Indemnification Agreement 2020-2021 School Year

PART I – TO BE COMPLETED BY THE PARENT OR GUARDIAN

I hereby authorize Commonwealth Academy personnel to facilitate the use of medication as directed by this authorization. I agree to release, indemnify, and hold harmless Commonwealth Academy and any of its officers, staff members, or agents from lawsuit, claim, expense, demand, or action, etc., against them for assisting this student with the use of medication, provided Commonwealth Academy staff comply with the physician or parent or guardian orders set forth in accordance with the provisions of Part II below. I have read this form and assume responsibilities as required.

Student's Name _____ Date of Birth_____School Commonwealth Academy
Name of Medication_____
Prescription: □ RENEWAL □ NEW If new, the first full dose must be given at home to assure that the student did not have a negative reaction. The first dose was given at _____ (date and time).

No Commonwealth Academy employee or volunteer shall facilitate the use of medication or treatment, as an exception under this policy, unless all of the required clearances have been personally reviewed by the Head of School or designee.

_____ _____ _____
Parent or Guardian Signature *Daytime Phone* *Date*

PART II – TO BE COMPLETED BY THE PHYSICIAN

(For over-the-counter medication for 3 days not prescribed by a physician or for an antibiotic for less than 10 days, Part II must be completed by a parent or guardian; in these instances a physician signature is not required.)

Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not facilitated in school except in specific emergency situations and scheduled insulin injections.
School personnel will, when it is absolutely necessary, facilitate the use of medication during the school day and while participating in outdoor education programs and overnights.

Diagnosis_____ Medication_____
If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again: _____

Dosage to be given at school _____ Time to be given at school _____
Effective Dates: from_____ to_____
If the student is taking more than one medication at school, list the sequence in which medications are to be taken.
_____

_____ _____
Physician Name (print or type) *Physician Signature*
Phone _____ *Date* _____

PART III – TO BE COMPLETED BY THE SCHOOL NURSE OR DESIGNEE

___ Parts I and II are completed, including signatures. (It is acceptable if all items of information in Part II are written on the physician's stationery or a prescription pad.)
___ Prescription medication is clearly labeled by a pharmacist.
___ Date by which any unused medication is to be collected by the parent (within one week after expiration of the physician order).

School Nurse or Designee Signature _____ *Date* _____

DISTRIBUTION: Original to Student Health/Medical History Record; **Copy** to Parent or Guardian
RETENTION: Until student withdraws or five years after graduation.