AFS MEDICATION PERMISSION FORM

This form must be completed for every prescription or over-the-counter medication that must be taken during the school day, including school sponsored activities and overnight trips (excluding Tylenol, ibuprofen, tums and Benadryl for which we have separate permissions and physician's orders.)

For daily and emergency meds: Return this form via Magnus Health and provide the medication in its original labeled container, on the first day or school, or prior to the start date. Please use one form per each medication.

For overnight trips: Return this form via Magnus Health no later than one week prior to trip and provide the medication in its original labeled container to the designated faculty member, just prior to the trip.

Please note: Self-administration on trips is for middle/upper school students only. All medication must be held by the designated faculty member. The bottle of medication will be passed to the student at the scheduled time. The student will require physician permission below to open the bottle, take the appropriate dose of medication, replace the cap, and return to the designated faculty member.

Health Care Provider Authorization

Medication Name_____ Dosage: _____

Time/frequency: _____ Start Date: _____ End Date: _____

Route:_____ Reason for medication:_____

For grades 5-12 only:
Is student authorized to carry/self-administer inhaler or epi-pen? Yes ☐ No ☐
Is student authorized to self-administer medication under direct supervision on trips? Yes ☐ No ☐

Health Care Provider Signature: _____

Health Care Provider Printed Name or Stamp:_____

Telephone: _____ Date: _____

Parent Authorization

Student's name: _____DOB_____ Grade_____

I (print parent/guardian name) _____hereby give my consent for my child/student identified above to receive the medication as dispensed/prescribed and I release AFS of all responsibility for any benefit and any and all adverse consequences of the medication. I also give consent for Abington Friends School Health Services Staff to communicate with our Health Care Provider for the benefit of my child/student.

Parent/Guardian Signature_____ Date_____