High Point Academy
Medication Administration Form

Student's First Name	Middle	Last

Please follow the guidelines below when bringing medication to school:

1. For student safety, all medication should be **brought to the clinic by the parent**.
2. All medication must be in its **original, properly labeled container** with a written request signed by the parent/guardian.
3. Only medication that cannot be given at home will be given at school.
4. Only a 30-day supply of medication will be accepted at a time. (Amount received by nurse_____.)
5. Medication that has expired or is not picked up by the parent will be destroyed.
6. Authorized district employees may administer medication in the absence of the nurse.
7. Aspirin or products containing aspirin will not be given without a physician order.
8. Nonprescription, homeopathic medication, dietary supplements and herbal supplements will only be given in accordance with High Point Academy Policies.

Medication _____ Dosage_____Time_____

Days to Give_____ Expiration Date :_____

Will this be the first dose of a new medication for your child? Please Circle. Yes or No

What is the condition for which this medication is required?

_____

Any special instructions/precautions/side effects of this medication for your child?_____

By my signature below, I affirm that it is impossible to schedule the above-mentioned medication at a time other than school hours. I request that this medication be given by a school employee. I acknowledge that I will not hold the High Point Academy, Board of Trustees, and/or District employees for damages or injuries resulting from administration of this medication (prescription/nonprescription/ homeopathic/over-the-counter), dietary supplement and/or herbal supplement.)

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals to share/obtain my student's health related information with the medical health professional or health care provider identified below to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein.

Parent Print Name _____Parent Signature_____

Date_____ Phone Number_____ Email address_____

Student's Health Care Provider_____ Phone Number_____

Physician's Signature_____ Date_____

A physician's signature is required to administer all prescription medications. It is also required for over-the-counter medication given for more than 10 consecutive days.

To Be Filed in the Nurses Office 6/13/2016