IMG SCHOOL HEALTH SERVICES

Medication Authorization Form

This form is to provide medical and parental authorization for medication to be administered while boarding at IMG Academy. Both the physician and parent/ guardian portions must be completed and signed before the medication may be administered. **Over the counter medication not approved to be kept in the dorm also need this form filled out including the physician section.**

This form is for the ☐ *2024- 2025 School year or* ☐ *while attending Camp.*

PART I TO BE COMPLETED BY PARENT/GUARDIAN

I hereby grant permission for Johns Hopkins All Children's Hospital Health Services Staff, or an IMG staff member trained on medication administration to administer the above prescribed medication to my child while boarding at IMG Academy, including when he/she is away from school property for official school events. I give permission to contact the physician prescribing this medication(s) to clarify information provided on the authorization should the need arise. It is my responsibility to notify the school clinic if these orders change.

Student Name_____ Date of Birth_____ Grade _____

Sport _____

Parent/Guardian Signature_____ Phone #_____ Date: _____

PART II TO BE COMPLETED BY PHYSICIAN/PROVIDER

Allergies:_____

Diagnosis: _____

MEDICATION	STRENGTH	DOSAGE	TIME(S) TO BE GIVEN	ROUTE	SIDE EFFECTS

Please check the appropriate box:

A medication prescribed requires screening labs. Explain: _____

If the student misses a medication routinely, will this change the status of the student being able to safely live in a structured independent boarding environment? Explain: _____

If a student misses a dose or is late with a dose, when should it be given? Explain: _____

_____

Physician's Name (Print)_____ Physician's Signature _____

Physician's Telephone #_____ Physician's Fax #_____

Date Completed _____

PART III TO BE COMPLETED BY SCHOOL HEALTH NURSE

Check as appropriate:

☐ Parts I and II are completed in entirety, including signatures.
☐ Prescription medication is property labeled by pharmacist.
☐ Medication authorization and medication label are consistent and pharmacy label is **NOT** expired.
☐ Controlled Substances have been signed into clinic by a parent or pharmacy member or school staff member and counted/verified with a school health nurse (if applicable).
☐ Medication entry has been verified for accuracy in school docs by two healthcare personnel.

_____ _____ _____

Healthcare Personnel (Signature) Healthcare Personnel (Signature) Date