

# TEMPLE RODEF SHALOM NURSERY SCHOOL

## MEDICATION AUTHORIZATION

(to be filled out by the Physician)

I certify that, in my opinion, it is medically necessary that the medication described below be administered to \_\_\_\_\_ during center hours and that this medication may be administered by MAT trained staff.

Reason child is taking medication: \_\_\_\_\_

Prescription:                      **Exact** Name of medication: \_\_\_\_\_

Amount/Dosage to be given: \_\_\_\_\_

Route of administration: \_\_\_\_\_

Frequency to be administered: \_\_\_\_\_

Date of Prescription: \_\_\_\_\_

Duration:                       Current school year 9/11-6/12

Next school year 9/12-6/13

For the following time period:

\_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mo) (day) (year) (mo) (day) (year)

This medication needs to be brought on field trips by a staff member:

\_\_\_\_\_yes

\_\_\_\_\_no

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

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### (TO BE FILLED OUT BY THE PARENT)

I, \_\_\_\_\_, the parent or guardian of \_\_\_\_\_, hereby authorize TRSNS staff to facilitate the use of the medication prescribed above as directed by this authorization to my child during school hours. I agree to release, indemnify, and hold harmless Temple Rodef Shalom, including the staff and Board of Directors, from any and all lawsuits, claims, expenses, demands, or actions, etc. against them for assisting my child with the use of this medication. The staff at TRSNS is directed to comply with the physician and parent/guardian orders set forth in accordance with the provisions above.

I understand that the person who will administer the medication has been trained through the Commonwealth of Virginia's MAT training program.

I agree to furnish said medication in the container supplied by the drug store with the label intact.

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

Social Services will not allow us to accept medication until this form is filled out in its entirety. All medications must be in original packaging. Prescription medication must have pharmacy label.

**PARENT REQUEST TO DISCONTINUE MEDICATION**

I, \_\_\_\_\_parent/legal guardian, request that the medication indicated on the front of this Medication Authorization form be DISCONTINUED on \_\_\_\_\_(date) and am removing it from the premises. Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written Medication Authorization form must be completed.

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)