TRINITY ACADEMY
MEADOW VIEW

Trinity Academy Meadow View - Prescription Medication Consent 2025-26

This form must be completed in lay language with no abbreviations. Licensed Health Care Provider signature required for prescription medications that are to be administered daily for 10 or more days. Prescription medication must be in the original container/packaging, including the pharmacists administration instructions.

Student's Full Name	Date of Birth	Known Drug Allergies

Part I - To be Completed by a Parent or Guardian

I, the parent/guardian, hereby authorize designated school personnel to administer medication to my child as directed by this authorization. I agree to release, indemnify, and hold harmless Trinity Academy Meadow View, its designated personnel, and agents from any lawsuits, claims, expenses, demands, or actions arising from the administration of this medication. I further understand that it is my responsibility to furnish this medication and any authorized refill. I understand that Trinity Academy Meadow View, its officers, agents, and/or any school employee who administer this medication to my child, in accordance with written instructions from the primary/prescribing physician, shall not be liable for damages as a result of an adverse reaction or any injury suffered by my child due to the administration or failure to provide the drug. The school reserves the right to not administer medication should circumstances warrant such action.

Parent or Guardian Name	Parent Signature	Date

Part II - To be Completed by a Licensed Healthcare Provider

Name of medication (including strength)_____

Amount/Dosage to be given _____ Route of administration _____

Frequency to administer_____ **OR** Specific Time _____

OR Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters).

_____

Possible side effects:

_____

What action should the school take if side effects are noted: _____

Special Instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. also describe situations when medication should not be administered.

_____

Reason the child is taking the medication (unless confidential by law): _____

Date consent form completed: _____

Date to be discontinued or length of time in days to be given (this date cannot exceed 12 months from the date authorized or this order will not be valid):

_____

_____

Licensed Prescriber's Name (Print or Type)

Licensed Prescriber's Signature	Phone	Date