SIDWELL SUMMER

For medications not listed on OTC Form

Medication Action Plan

Student_____ **Date of Birth**_____ **Grade**_____

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Sidwell Friends School personnel to administer medication as directed by the physician (Part II below) to my child as named above. I agree to release, indemnify, and hold harmless Sidwell Friends School and its employees and volunteers, from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, as directed by the physician's order as written in Part II below.

_____ _____ _____

Parent/Guardian's Name (Print) ***Signature*** ***Date***

PART II: TO BE COMPLETED BY THE PHYSICIAN/HEALTH CARE PRACTITIONER

Please complete and sign this medication order allowing Sidwell Friends School personnel to administer the prescribed medication for the child named above, according to the procedures outlined on page 2.

Name and Strength of Medication	Time and Frequency	Diagnosis	Expected Duration of School Administration	Can a Reaction be Expected? Yes/No	If yes, Please Describe Possible Side Effects:	Special Instructions:

_____ _____ _____ _____

Health Care Practitioner's Name (print) ***HealthCare Practitioner's Signature*** ***Phone Number*** ***Date***

SELF-CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION

Self-carry/self-administration of medication must be authorized by the prescriber. This child has the knowledge and skills to self-carry and self-administer the prescribed medication:

_____ _____

Health Care Practitioner's Signature ***Date***