

Child Name: _____

Grade: _____



The Jewish Primary Day School of the Nation's Capital



AUTHORIZATION TO ADMINISTER MEDICATION AND PERMISSION FOR EMERGENCY MEDICAL TREATMENT 2011-2012

IMPORTANT: In accordance with the laws of the District of Columbia, JPDS Staff can not administer any type of medication without a signed doctor's note. This includes all types of over-the-counter medication, ointments, creams, etc., as well as prescribed medication.

A separate form is needed for each child and for each medication required.

If you would like your child to receive any medications, please do the following:

1. Present a written Consent to Administer Medication Form signed by the parent or legal guardian. **(Part I)**
2. Present a written Physician's Medication Authorization Order completed and SIGNED BY A DOCTOR. **(Part II)**
3. Present a written Authorization to Administer Over-the-Counter Medications Form completed and signed by both a parent and A DOCTOR. **(Part III)** The law will not allow us to medicate your child without written permission, even with a telephone request from a parent.
4. Medication must be brought in BY AN ADULT in the original prescription bottle properly labeled by a registered pharmacist as prescribed by law. NO baggies, Tupperware, etc. will be accepted.

JPDS-NC has the right to refuse to accept or administer medication if any of the above regulations are not followed.

The Jewish Primary Day School of the Nation's Capital and its representatives have my permission in an emergency when my physician or I cannot be contacted to administer care and treatment for my child including care and treatment for injuries and illnesses and administration of medication. The school representative may hospitalize and/or secure proper treatment for my child in case of medical emergency, if in their best professional judgment further delay might jeopardize the welfare of my child. I give permission to release pertinent medical information to JPDS-NC faculty and its representatives on a need-to-know basis. I give permission to release information from my child's medical file to emergency personnel, or a doctor's office or hospital, including by fax if necessary, in order to facilitate proper medical care. I have read the above guidelines and agree to adhere to them and I understand that this authorization is valid only for the 2010-2011 school year.

Parent/Guardian Signature: _____

Date: _____

Print Name: _____

Student Name: _____

**Please complete and return this form for each child by July 22, 2011 to:
schoolforms@jpbs.org or to 6045 16th Street, NW, Washington, DC 20011.**

Child Name: _____

Grade: _____

- Part I -

**CONSENT TO ADMINISTER MEDICATION FORM
(To be filled out by parent/legal guardian)**

I hereby request and authorize the Jewish Primary Day School of the Nation's Capital (JPDS-NC) personnel to administer medication as directed by my physician. I agree to release, indemnify and hold harmless JPDS-NC and any of its officers, staff members, or agents from lawsuit, claim demand, or action, etc. against them for administering medication to this student, provided JPDS-NC staff are following the Physician's Medication Authorization Order as written in Part II. I have read and discussed the medication policy with my child and assume the responsibilities as required.

Medication may be given by school personnel only if the prescribing physician completes the Physicians Medication Authorization Order and the Authorization to Administer Over-the-Counter Medications Form (Part II). JPDS-NC will make all reasonable efforts to give medication in a timely fashion, but the final responsibility for administration of medication rests with the parents.

PLEASE PRINT CLEARLY

Student's Full Name: _____

Date of Birth: _____ **Grade:** _____ **Teacher:** _____

I, _____, give permission for my child to receive the following medication as directed by a physician:

Signature: _____ **Date:** _____

Print Name: _____

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

Emergency Contact Name: _____

Phone Number: _____

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- Part II -

**PHYSICIAN'S MEDICATION AUTHORIZATION ORDER
(To be filled out by the doctor)**

The Jewish Primary Day School of the Nation's Capital discourages the administration of medication to the pupils in school during the day. Any necessary medication which can possibly be administered before or after school should be given before or after school. No medications will be administered without this Physician's Medication Authorization Order. School personnel will, when it is absolutely necessary, administer authorized emergency medication such as epi-pens to pupils during the school day, while participating in outdoor education programs, and/or overnight field trips, according to the procedures outlined. These medications must be accompanied by a care plan signed by a doctor.

PLEASE PRINT CLEARLY

Student's Full Name: _____

Diagnosis: _____

Medication: _____

Dosage and route: _____

Time and Directions to be Given: _____

Effective Dates: _____

Physician's Name: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Physician's Signature and Stamp: _____ **Date:** _____

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Grade: _____

-Part III-

AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

JPDS-NC Staff will not administer over-the-counter medication to any student without express authorization from a parent and a physician presented on this completed form.

I authorize JPDS to use its discretion to give my child any of the initialed medications noted below.

I wish to be called before JPDS administers the following medications:

I wish to be called before JPDS dispenses any medication.

I do not want my child to receive any medication at school.

Student Name _____ Grade _____

Parent Signature _____ Date _____

Over- the-counter medications:

Acetaminophen (Tylenol)

Hydrocortisone cream

Antibiotic ointment

Ibuprofen (Advil or Motrin)

Benadryl (diphenhydramine)

My child has medication allergies (please check)

Yes No If yes, please list here: _____

FOR THE PHYSICIAN

It is medically safe for the above-named student to receive the initialed medication(s).

Physician Signature: _____ Date: _____

Physician Name and Stamp: _____

Physician Phone Number: _____

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