The Putney School SUMMER ARTS
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2018 AUTHORIZATION TO ADMINISTER MEDICATION

Student Name:_____Date of Birth :_____
Drug Allergies & Reaction:_____

MEDICATION POLICY

All medications, non-prescription or prescription, and/or supplements/vitamins must be reported to and approved by Health Services. Most prescription medications are administered by or through Health Services, and exceptions are at the discretion of Health Services. All medications should be sent direct to Health Services, not to the student. Each prescription medication must have a completed and signed Medication Order form on file in Health Services. Prescription medications taken any time during the day are administered out of the Health Services office; prescription medications taken after 7:30pm are packed by a nurse and stored in a lock-box in the dorm, to be handed out by a dorm head. Students must take their medication in the presence of the administering adult.

MEDICATION POLICY AGREEMENT (ALL PARENTS/GUARDIANS)

I have read and understand the medication policy at The Putney School and agree to abide by its guidelines. I have reviewed the guidelines with my child. I understand that my child cannot possess any medication (over-the- counter, herbal, natural remedies, or prescription) without receiving permission from a school nurse. I am responsible for promptly updating Health Services with any changes in medications or as new medications are prescribed. I understand that discontinued medications, including dosage changes, will be disposed of through the Windham County Sheriff's Office within two weeks unless I make other arrangements with Health Services. I understand that violation of the medication policy may result in a disciplinary hearing for my child.

Parent/guardian initials _____

PRESCRIPTION MEDICATION ADMINISTRATION CONSENT (ALL PARENTS/GUARDIANS)

I give permission for Health Services or school personnel designated by Health Services to administer prescription medications prescribed to my child. These medications may include prescriptions my child is currently on or medication prescribed while my child is at school. Prescription medications from home must be accompanied by a Medication Order form signed by the prescribing caregiver. I understand that a new Medication Order form is required for every change in a prescribed medication's administration. I understand that all prescription medication must be kept in its original pharmacy container with the appropriate label specifying student name, medication, dosage, route, and frequency or time of administration, and other special instructions.

Parent/guardian initials _____

OVER-THE- COUNTER MEDICATION ADMINISTRATION (ALL PARENTS/GUARDIANS)

I give permission for Health Services or school personnel designated by Health Services to administer standard over-the- counter medications (exclusions noted below) to my child according to guidelines approved by the school physician. **Parent/guardian initials _____**

Exclusions: _____

PARENTAL CONSENT FOR SELF-ADMINISTRATION OF MEDICATION (ALL PARENTS/GUARDIANS)

I give permission for my child, at the discretion of Health Services, to self-administer a specified medication. I feel comfortable that my child can responsibly administer their own medications. The Putney School can provide support and teaching to students taking medication, but does not assume responsibility for students who self-administer medications (prescription, over the counter, or natural/herbal remedies) as prescribed by a physician. The option for self-administration excludes all controlled substances, which must be stored according to school policy and administered by Health Services or school personnel designated by Health Services.

Parent/guardian initials _____

STUDENT AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION (ALL STUDENTS)

1. I have read the medication policy and will abide by its guidelines.
2. I understand that I am responsible for taking medications as directed, including going to Health Services during the day or contacting my dorm head in the evening.
3. I will report lost medication to Health Services immediately.
4. I agree to contact an adult on campus if I do not feel well, or if I have a question about my medication.
5. I agree to NEVER share or sell my medication with or to anyone.
6. I agree to NOT keep medications in my dorm room or with me unless authorized to do so by Health Services.
7. I understand that not following these guidelines may result in a disciplinary process. **Student initials _____**

Student Signature: _____ Parent/guardian signature: _____