FRONTIER SCHOOLS

Address:
6800 Corporate Dr
Kansas City, MO 64120

Phone:
(816) 241-6200
Fax:
(816) 241-6201
Website:
www.frontierschools.org

PRESCRIPTION MEDICATION AUTHORIZATION FORM

Student Name: _____

Date of Birth: _____/_____/_____ **Grade/Section:** _____/_____

Address: _____

Phones: (_____) _____ (_____) _____ (_____) _____
Home Mobile Work

Emergency Phone: (_____) _____ (A relative or a friend's number)

I, _____ parent or guardian of _____, hereby authorize Frontier Schools and its employees and agents, in my behalf and in my stead, to administer to my child (or to allow my child to self-administer, while under the supervision of the employees or agents of Frontier Schools), lawfully prescribed medication in the manner described below. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Frontier Schools, its employees and/or agents arising out of the administration of said medication. In addition, I agree to indemnify and hold harmless Frontier Schools, its employees and agents, either jointly or severally, from and against any, and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication.

_____ _____
Parent's Signature Date

Please list all medication that your child is taking at home: _____

_____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

(Use additional pages if needed)

Diagnosis: _____

Dosage: _____ Time/Frequency: _____

Route of Administration: _____

Type of Disease or Illness: _____

If PRN, state frequency or indication: _____

Must this medication be administered during the school day in order to allow the child to attend school? ☐ Yes ☐ No

Are there any side effects to the medication? ☐ Yes ☐ No --- *If yes, specify*: _____

Is this drug covered by the psychotropic drug law? ☐ Yes ☐ No

Other Recommendations: _____

_____ _____/_____/_____ _____
Physician's Name (Print) Date Physician's Signature

_____ _____
Address Telephone Number

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FORMULARIO DE AUTORIZACION DE MEDICAMENTOS PRESCRIPTOS

Nombre de Estudiante: _____

Fecha de Nacimiento: _____/_____/_____ **Grado/ Sección:** _____/_____

Dirección: _____

Numeros: (____) _____ (_____) _____ (_____) _____
Casa Celular Trabajo

Teléfono de Emergencia: (_____) _____ (Un familiar o el número de un amigo)

Yo ,_____padre o tutor de_____, por la presente autorizo a la escuela de Frontier Schools y de sus empleados y agentes, en mi nombre y en mi lugar, para administrar a mi hijo (o para permitir que mi hijo autoadministrarse , mientras que bajo la supervisión de los empleados o agentes del Frontier Schools, legalmente prescribir medicamentos de la manera descrita a continuación. Además, reconozco y acepto que, cuando se lo administra el medicamento prescrito legalmente, renuncio a cualquier reclamación que pueda tener contra el Frontier Schools, sus empleados y / o agentes derivados de la administración de dicho medicamento. Además, estoy de acuerdo en indemnizar y mantener indemne al Frontier Schools, sus empleados y agentes, ya sea conjunta o separadamente, de y contra cualquier y todo reclamo, daños, causas de acción o lesiones, incluyendo honorarios y costos gastados en defensa de la misma razonables de abogados, incurrido o que resulten de la administración de dicho medicamento.

_____ _____
Firma de Padre Fecha

Por favor enumere todos los medicamentos que el niño toma en casa: _____

_____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

(Use additional pages if needed)

Diagnosis: _____

Dosage: _____ Time/Frequency: _____

Route of Administration: _____

Type of Disease or Illness: _____

If PRN, state frequency or indication: _____

Must this medication be administered during the school day in order to allow the child to attend school? ☐ Yes ☐ No

Are there any side effects to the medication? ☐ Yes ☐ No --- *If yes, specify*: _____

Is this drug covered by the psychotropic drug law? ☐ Yes ☐ No

Other Recommendations: _____

_____ _____/_____/_____ _____
Physician's Name (Print) Date Physician's Signature

_____ _____
Address Telephone Number