Parent: please fill out the highlighted areas ONLY, we will fax the remainder to be completed by the physician.

Dear Doctor:

1. **PARENT REQUEST TO RELEASE MEDICAL INFORMATION**

In line with Hopewell/Bridgepoint Academies Policy and Procedures on the Self-Administration of Medicine in school, please complete the following information on my Child (Name)____ and bring it to the School Administrator at Hopewell/Bridgepoint Academies.

*Meds must be brought to school by an adult (over 21) and packaged in the original, prescribed containers even if only one tablet/capsule will be dispensed. No medications can be brought in to school by students and these medications WILL NOT be accepted if transported via a student.

____ ________________________

Signature of Parent/Guardian Date

2. **MEDICAL AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICINE DURING SCHOOL HOURS** (summer term: 8am to noon, Fall term: 9am to 2:30pm).

Name of Child ______________________________ Grade _______ School _____________________________

Name of Medication

____

Dosage(s) and Time(s)

____

Necessity for the medication during school hours ____

____

Type of disease or illness involved ____

Benefits of the medication ____

Any side effects ____

____

____ ___________________________

Doctor's Signature Date

3. **PARENT'S REQUEST TO ADMINISTER MEDICATION**

I hereby request that Hopewell/Bridgepoint Academies personnel supervise the self-administration of medication ordered by:

Dr. ____________________________________ phone #________________________________ for My child during school hours.

_______________________________________ ______________________________

Signature of Parent/Guardian Date