Permission for School Administration of Medication

For School Use Only:
____ Routine
____ PRN (as needed)
Start Date:
_____

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before should not be given at school. Medication to be given at school should be accompanied by this form, complete with the prescribing physician's signature, and provided to the school in the original labeled container. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name and directions for proper administration.

This section to be completed by the prescribing health care provider:

Child's name	Date of Birth
Name of School	Grade
Medication	Substitution permitted
Purpose	Dosage
Route	Frequency
Time Medication to be given at school:	
Requirements: _____ None _____ Refrigerate _____ Other (please specify)	
Anticipated number of days medication will be given at school ____ until end of current school year ____ weeks ____ days	
Is child allergic to any food, medicines, or other items? __ NO __ YES (List allergies.)	Is this medication a controlled substance: _____ NO _____ YES Possible Side Effects:

Prescribing Health Care Provider's Signature:_____
Date Stamp, Print, or Type Health Care Provider's Name and Address:

_____

Office Phone Number _____ Office Fax Number_____

This section to be completed by child's parent or guardian:

I give permission for my child, _____, to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I will not hold the school, or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. I will notify the school if my child's medications change.

_____Signature of Parent / Guardian _____Date

_____ _____

Print or Type name of Parent / Guardian Day Phone Number

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