Prescription Medication Form

Permission for School Administration
(This form must be completed by the child's prescriber and parent/guardian.)

Please note the following requirements:

1. Medication must be brought to the school nurse by a responsible adult. (***Do not send with a child***.)
2. Medication should be administered by a parent/guardian before or after school hours, when possible.
3. All prescribed medications must be provided to the school in the original labeled container issued by the pharmacist and accompanied by this permission form. (The label and the prescriber's order on this form must match)
4. Any prescribed controlled substance must be brought to the school nurse by the parent when the prescription is filled each month and must be provided to the school nurse in the most recent pharmacy labeled container.
5. "Sample" medication must be provided in a container appropriately labeled, which identifies the medication and must be accompanied by a note signed and dated by the prescribing provider that includes the student's name and directions for proper administration, along with this permission form.
6. First doses of a medication that a child has never received will not be given at school.
7. HCS district may reject requests for certain medications to be given at school.
8. Herbal substances are not considered medication and will not be administered by the school nurse.

Child's Full Name: _____ Date of Birth: _____

Gender: Male or Female **Grade Level ___ Teacher: _____**

Section below must be completed by the Child's Prescribing Health Care Provider:

Name of prescription medication to be given at school	**Prescribed route:**	**Controlled substance**? Yes or No	List possible **side effects** from this medication:	**Reason(s) for this Medication** to be given at school:
Number of days medication is to be given at school:	Special **storage** requirements: No or Yes Describe:	Prescribed **dosage/strength** i.e. 50 mg, mcg, grams	**Amount** to be given at School**:** (i.e. 1 tab, 5 ml, 0.5 tab, 2 puffs)	**Frequency/Time** to be given at school**:** (Please specify preferred time. "Lunch" times vary from 10:30a-1p)

Prescribing Health Care Provider's Name & Office: ***(please print or stamp)***

Office Phone / Fax: _____

Signature of Prescriber: **_____**

Date: **_____**

****Please note that this form is only valid if signed on or after July 1 for the upcoming school year.***

Section below must be completed by the Child's Parent and/or guardian:

Does this child have **any known allergies?** ☐ No ☐ Yes
(If yes, list all known allergies and type of reaction(s):
_____

Does this child **take any additional medications at home or at school?** ☐ No ☐ Yes
(If yes, list the medications taken at home):
_____

I agree with all of the following:

- I give permission for my child to be given the above medication as prescribed while at school.
- I give permission for information about this medication and/or my child's health to be exchanged between the Faith First Academy school nurse or designated Faith First Academy employee and/or the Health Care Provider, the prescriber, the pharmacist who filled this prescription, and/or their designee.
- I further give permission for information about my child to be shared with persons who legitimately need to know for the safety and well-being of my child.
- I agree to follow the FFA policies concerning medications and that medication will be given per the FFA policies.
- I agree I am responsible for providing the school with the medication for my child and any supplies needed.
- I agree that I am responsible for notifying the school if my child's health and/or medication(s) change in any way.

_____ _____

Parent/Guardian's Signature **Date**

_____ _____

Parent/Guardian's Name (Print) **Daytime**

Updated 7/20/22