Permission for Medication Administration at School

The parent/guardian of _____ ask that school staff give the following
Child's Name

medication_____ at _____ to my child, according
Name of Medicine & Dosage Time(s)

to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in the container labeled with: child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, and licensed Health Care Provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed Health Care Provider authorization, and medicine must be packaged in original container.

The school agrees to administer medication prescribed by a licensed Health Care Provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

By signing this document, I give permission for my child's Health Care Provider to share information about the administration of this medication with the school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Alternate Phone

Health Care Provider Authorization

Child's Name:		Birthdate:
Medication:	Dosage:	Route:
To be given at the following times:	Start Date:	End Date:
Special Instructions:		
Side Effects to be reported:		

_____ _____
Signature of Health Care Provider with Prescriptive Authority Date

_____ _____
Print Name of Health Care Provider Phone & Fax Number

_____ _____
Signature of Child Care Health Consultant of School Nurse Date