Permission for School Administration of Prescription Medication

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 and provided to the school in the original labeled container provided by the pharmacist who filled the prescription. "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, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.

Child's Name_____ Date of Birth_____

Name of School_____ Grade_____

<table>
<tr><td colspan="2">Medication:</td><td colspan="2">Dosage:</td></tr>
<tr><td colspan="2">Purpose of Medication:</td><td colspan="2">Route:</td></tr>
<tr><td>Time medication to be given at school:</td><td colspan="2">Frequency (e.g., daily)</td><td>Note special storage requirements: __None __Refrigerate __Other (please specify):</td></tr>
<tr><td colspan="2" rowspan="2">Anticipated number of days medication will be given at school: ◊ until end of current school year
◊____weeks ◊____days</td><td colspan="2">Is child allergic to any food, medicines, or other items ___No ___Yes (List allergies)</td></tr>
<tr><td colspan="2">Is this medication a controlled substance __No __Yes</td></tr>
<tr><td colspan="4">Possible Side Effects:</td></tr>
</table>

<table>
<tr><td rowspan="2">Health Care Provider's Name & Address:</td><td>Office Phone Number:</td></tr>
<tr><td>Office Fax Number:</td></tr>
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Section below 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 a school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this mediation 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 school administrators. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if my child's medications change in any way.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Print or Type Name of Parent/Guardian Day Phone Number