



## Permission for School Administration of Prescription Medication

For school use only:

- Routine  
 PRN (As needed)

Start Date: \_\_\_\_\_

When possible, medications should be administered by a parent or guardian before or after school hours. 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:		Dosage:
Purpose of Medication: <b>ICD</b> code: _____		Route:
Time medication to be given at school (Lunch times vary: 10:30a – 1p)	Frequency (e.g., daily)	Note special storage requirements <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other (please specify):
Anticipated number of days medication will be given at school: <input type="checkbox"/> until end of current school year <input type="checkbox"/> ____ weeks <input type="checkbox"/> ____ days	Is child allergic to any food, medicines, or other items? <input type="checkbox"/> No <input type="checkbox"/> Yes (List allergies.)	
	Is this medication a controlled substance? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Possible Side Effects:		

Prescribing Health Care Provider's Signature \_\_\_\_\_

Date \_\_\_\_\_

Stamp, Print or Type Health Care Provider's Name & 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 also give permission for this "Permission for Prescription Medication" form to apply if I transfer my child to another school in this same school district during the current school year. 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 will not hold the district, school district, or school personnel liable for any adverse drug reactions when medication is administered according to 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 \_\_\_\_\_

