Permission for School Administration of Prescription Medication /

For school use only:
‘ Routine
‘ PRN 18 w 0 0 m 0 6 l S Q q 0.119995

Time medication to be given at school (Lunch times vary (10:30a – 1p)	Frequency (e.g., daily)	Note special storage 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 & Address:	
	Office Phone Number
	Office Fax Number

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 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" 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 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