



## Administration of Prescription Medication at School

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Is your child allergic to any food, medicines, or other items?  No  Yes

If yes, list allergies: \_\_\_\_\_

Name of medication to be given at school: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Amount of medication to be given: \_\_\_\_\_

Time of day medication to be given at school: \_\_\_\_\_

Estimated time medication will be given at school \_\_\_\_\_

Note any special storage requirements:  Refrigerate  Other (please specify) \_\_\_\_\_

Does your child take any other medications at home or at school? No Yes

If yes, what are the medications?: \_\_\_\_\_

Child's Health Care Provider's Name and Address (please print):

\_\_\_\_\_  
\_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school administrator. I understand that I am responsible for notifying the school if any of my child's medications change.

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print or Type Name of Parent / Guardian

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Day Phone Number