PERMISSION FOR MEDICATION ADMINISTRATION AT SCHOOL

Student Name: _____

School:_____

In order for the school to administer any prescription or over-the-counter medication to your child, you must provide the school with written orders from your child's healthcare provider. All medications must be provided in their original container and labeled with your child's name. Please return this form to:

Name: _____
Title: _____
Phone/e-mail: _____

By signing this form, I give permission for my child's healthcare provider to share information about the administration of this medication with the school staff delegated to administer medications. I further authorize the school personnel delegated to administer medications to administer the medication(s) identified in the following section in accordance with my healthcare provider's instructions.

Parent/guardian's signature: _____
Printed name of parent/guardian: _____
Date: _____

This section must be completed by your healthcare provider

HEALTHCARE PROVIDER AUTHORIZATION

CHILD'S NAME:

Birth date:

Medication:

Dosage:

Route:

Administration time(s):

Start Date:

End Date:

Special instructions:

Any aide effects to reported:

Signature of healthcare professional with prescriptive authority: _____

Printed name of healthcare professional: _____

Phone/e-mail: _____

Date: _____