Motivate Collaborate Support Develop

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Permission for Medication Administration in School

Name of Student:_____D.O.B:_____

School:_____Grade:_____ Teacher:_____

Medication:_____

Dosage:_____ Route:_____Time(s):_____

Purpose of medication:_____

_____

Possible side effects:_____

_____

Anticipated number of days it needs to be given at school:_____

_____

Healthcare Provider **Printed** (Physician, NP, PA)

_____

Healthcare Provider Signature Date

I hereby give my permission for my child to receive the above medication from the School Registered Nurse(s) at school per orders. I understand that Unlicensed Assistive Personnel as trained, delegated, and supervised by the School Registered Nurse(s) may administer the above medication to my child at school. I understand that it is my responsibility to provide this medication in the original box/container with the corresponding prescription label intact and non-expired. Any over the counter medication must be in the original box/container and unopened at the time it is provided to the school. I hold the district and its employees free from any and all responsibility for the results of administering this medication to my/our child while at school.

_____

Parent/Legal Guardian **Printed**

_____

Parent/Legal Guardian Signature Date

3/2017