PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

Complete one form for each medication (prescription or over-the-counter.)

Student Name: _____ Date of Birth: _____

Medication: _____

Reason for medication: _____

Dosage: _____ Route: _____ Time: _____

If 'as needed' (PRN), indicate when dose can be repeated: _____

Special Instructions: _____

Possible Side Effects: _____

Start Date: _____ End Date: _____

Name of Health Care Provider: _____

Office Phone Number: _____ Fax: _____

Signature of Health Care Provider with prescriptive authority:

_____ Date: _____

I understand that whenever possible, medication should be administered at home. I also understand that it is my responsibility to furnish the medication to school in the original pharmacy-labeled container or over-the-counter container marked with my child's name. Any prescription changes will require an additional signed and completed 'Permission to Administer Medication' form.

I give my permission for the school staff to contact the prescribing physician regarding this medication. I understand that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Academy District 20, the undersigned parent or guardian agrees to release Academy District 20 and its personnel from any legal claim which he, she or their child may now have or may hereafter have arising out of side effects or other medical consequences of the medication. I hereby give my permission for the student named above to take the above medication at school as ordered.

Name of Parent/Guardian: _____

Contact phone numbers (home, cell, other): _____

Parent/Guardian Signature: _____ Date: _____

Revised: 06-17-2020