

**Permission to administer PRESCRIPTION medications during school attendance**

COMPLETED by **HEALTH CARE PROVIDER**:

Student: \_\_\_\_\_ Grade: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date of Initial Dosage: \_\_\_\_\_

Reason for Rx: \_\_\_\_\_

Instructions for Administration: \_\_\_\_\_

Time of day Rx to be given:  After Lunch  As Needed  Other Time: \_\_\_\_\_

Anticipated duration of Rx at school:  School Year  Other: \_\_\_\_\_

PRINTED name of prescribing physician: \_\_\_\_\_

**Health Care Provider Signature (REQUIRED)**

**Date**

**COMPLETED by PARENT / GUARDIAN**

**Checklist must be complete!**

- Primary Care Provider section fully completed
- Prescription Medication is:
  - In the ORIGINAL container
  - MUST CONTAIN A PHARMACY LABEL with:
    - ✓ Name of student
    - ✓ Name of medication
    - ✓ Dose & time to be administered
    - ✓ Number of days to be administered
    - ✓ Current prescription date
- If student will carry & self-administer medication for the treatment of anaphylaxis or asthma (ex: inhaler, Epi-Pen, Auvi-Q) the form **Permission for Self-Administration of Medication** must **ALSO** be completed and signed by the Health Care Provider

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over the counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and has experienced no adverse reactions

**Parent/Guardian Signature (Required)**

**Date**

**Permission to administer NON-PRESCRIPTION medications during school attendance**

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COMPLETED by **PARENT / GUARDIAN:**

Student: \_\_\_\_\_ Grade: \_\_\_\_\_

I give my permission for school personnel to administer over the counter medication (s) to the above name student for minor discomforts and injuries.

Please check YES or NO for all of the following:

- |                              |                             |                            |                              |                             |                                       |
|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|---------------------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Antibiotic ointment        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Ibuprofen (generic for Advil, Motrin) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hydrocortisone cream       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Acetaminophen (generic for Tylenol)   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Antiseptic cleanser        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Cough drops                           |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Antacid (generic for Tums) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Eye drops (non-medicated)             |

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COMPLETED by **PARENT / GUARDIAN:**

Permission to administer NON-prescription medications during school attendance, other than those listed above:

If a student brings any medication from home it must be in the ORIGINAL container, labeled with the student's name and accompanied by this permission form signed by the parent/guardian

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date of Initial Dosage: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Instructions for Administration: \_\_\_\_\_

Time of day Rx to be given:  After Lunch     As Needed     Other Time: \_\_\_\_\_

Anticipated duration of Rx at school:  School Year     Other: \_\_\_\_\_

PRINTED name of Parent / Guardian: \_\_\_\_\_

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over the counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and has experienced no adverse reactions

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**Parent/Guardian Signature (Required)**

**Date**