

*** PARENT/GUARDIAN and PRESCRIBING HEALTH PROFESSIONAL REQUEST FOR ADMINISTRATION OF MEDICATION**

ALL medications **MUST** be given directly to the School Nurse, Health Assistant, Principal or Assistant Principal **by the parent or legal guardian**, unless the Nurse or Health Assistant allows a change in delivery.

These medications **MUST** be in their original prescription bottle/packaging, with the pharmacy label clearly visible, and a **current expiration date**.

The label **MUST** contain the prescribing health professional's name, the date of the original prescription, along with the name, strength and directions for giving the medication.

"Over-the-counter" medications (OTC's - such as Excedrin, Motrin, aspirin, etc.), **MUST** be in the **original labeled container and have a current expiration date**. *****

Rx Date ___/___/___ Rx Start Date ___/___/___ Dates of Administration ___/___/___ to ___/___/___

*** PLEASE PRINT CLEARLY**

Student's Name _____ DOB ___/___/___ Grade _____

Parent/Guardian's Name _____ * EMERGENCY Phone _____

* Second Person for Emergencies _____ Phone _____

Prescribing Health Professional _____ Phone _____

_____ / _____ / _____ Fax _____

Health Practice Name _____ Town _____ State _____

Medication Name _____ Dose _____ Route _____

Reason for Medication _____ Time/s of Administration _____

Possible Side Effects of Medication ~ **IN YOUR CHILD:** _____

PLEASE NAME: **ALL other medications** taken [at home or at school] _____

PLEASE SPECIFY: **Any restrictions** of activities [sports, shop, lab, driver's training, PE, etc.] _____

*** PARENT/GUARDIAN PERMISSION FOR GIVING MEDICATION AT SCHOOL**

By signing this statement, I am giving permission for the above named medication to be administered to my child while at school. I also agree not to hold any member of the school staff, directed by me and/or the school administrator, libel for assisting my child in taking this specific medication.

* **PARENT/GUARDIAN SIGNATURE** _____ Date ___/___/___

Upon receipt of this completed form, the Health Office staff will fax it to the above named Prescribing Health Professional for their signature.

* **PRESCRIBING HEALTH PROFESSIONAL, PLEASE NOTE PARENT/GUARDIAN'S SIGNATURE ABOVE**

I, the undersigned Prescribing Health Professional, request that the School Nurse, Health Assistant or other designated person administer the medication I have prescribed. I certify that failure to administer the medication may jeopardize the health of my patient.

Date ___/___/___

* _____ / _____
PRESCRIBING HEALTH PROFESSIONAL'S SIGNATURE/ PRINTED NAME