PERMISSION TO GIVE MEDICATION AT SCHOOL

Students requiring medication administration during school hours must have the following information supplied to the school nurse.

1. Written authorization is to be provided to the school from the private physician, detailing the diagnosis or type of illness involved the name of the drug, dosage, time of administration, and the side effects, if any.
2. Parental signed consent.
3. The medication in the original container with a prescription label or the "over the counter" label.

Name of student _____ Grade _____

Date of Birth _____

*** To Be Completed By Physician**

Medication _____ Dosage _____

Time(s) _____ Route _____

If **P.R.N.**, list indication for use: _____

Possible significant side effects: _____

Duration ____ until further notice, ____ other _____

Are there any restrictions? ___ Yes ___ no if yes, describe _____

Student ___ may, ___ may not miss a dose of medication to attend a field trip or special activity.

Should the medication be given on early dismissal days?_____yes_____no

_____ _____ _____

Printed Name of Physician Signature of Physician Date

***For Self Administration Only**

Self administration of medication may be performed by pupils with potentially life threatening illness, namely severe allergic responses and asthma. The above named pupil is capable of and has been instructed in the proper technique of self administration. The pupil is physically fit to attend school.

Physician's Signature _____

***To Be Completed By Parent/ Guardian**

I, _____, give permission for my child to receive the above medication as directed by the physician. If my child may self medicate for asthma, I have attached the required completed Asthma Action Plan. I understand my child's photo will be taken and attached to this form.

Parent/ Guardian
Signature: _____ Date: _____