PERMISSION FOR PRESCRIPTION MEDICATION

ANDERSON SCHOOL DISTRICT 5 SCHOOL HEALTH PROGRAM

TO BE COMPLETED/SIGNED BY HEALTH CARE PROVIDER

Student's Name: ______________________________ DOB: ______________

Name of School: ______________________________ Grade/Teacher: ______________

Medication: ______________________________ Dosage: ______________

Purpose of Medication: ______________________________ Route: __________ **ICD-10 ________

ALLERGIES: ______________________________

Time of day medication is to be given at school: ☐ First dosage to be given at home ☐ PRN (as needed)

____ 8:00 a.m. ____ 10:00 a.m. ____ 12:00 p.m. ____ 2:00 p.m. ______ Other

Anticipated number of days medication needs to be given at school:

____ Until the end of the current school year ____ Weeks ____ Days __________ End Date

Special Notes: ______________________________

Special storage requirements: ____ Refrigerate __________ Other

Side Effects: ______________________________

Printed Name, Address, and Phone Number of Health Care Provider: ______________________________

____

SIGNATURE OF HEALTH CARE PROVIDER: ______________________________ Date: ______________

Important: For Inhalers, Epi-Pens and Insulin Pumps
Due to the State law effective May 2005, this student's medical condition may warrant him/her to be allowed to self-medicate/self-monitor. After your examination and discussion with student and parent, if this is an option, the parent must notify the school nurse for mandated paperwork.

TO BE COMPLETED BY PARENT OR GUARDIAN

I give permission for the school nurse, school principal or his/her designee to administer the prescribed medication to my child______________________________ while at school. I will deliver the medication to school in the original container with a pharmacy label. I give permission for the school principal or the school nurse to contact the health care provider named above to discuss and share information regarding my child's medical condition and/or medication. I am responsible for notifying the school nurse/principal if there are any changes in my child's health condition or plan of care. Any medication not picked up by the last day of school will be destroyed.

Signature of Parent/Guardian: ______________________________ Date: ______________