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_____ Teacher's Name_____

Medication_____Dosage_____

Purpose of Medication_____Route_____

ALLERGIES: _____

Other medications the student is currently taking (prescribed and OTC): _____

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:
(HCP Please Note: For rescue inhalers, please indicate specific # of days/weeks the student is to use the inhaler, if other than PRN.)

_____ Until the end of 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 new 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 school nurse will forward you the additional mandated paperwork.

If you have questions about the new State law, please contact me at the following number:

*School Nurse*_____ *School*_____
*Phone No.*_____

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 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.

Signature of Parent/Guardian_____ Date_____