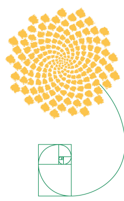

PERMISSION TO ADMINISTER MEDICATION FORM - 2018-2019

Completion of this form is required for any prescribed medication to be administered at school (for example: Epi-pen, inhaler, allergy medication etc.) and also for any over - the - counter medication not described in the FIRST AID AUTHORIZATION AND CONSENT.

Student Name: ________________________________Class-Grade__________________

SECTION TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Name of Medication: Is this medication prescribed by a doctor? ❑ Yes ❑ No	Purpose of Medication:
Dosage: _____ (amount) _____ X per day or as needed (complete/circle) Method of Administration: Time of Administration (If more than one dose is required while in school, please specify). _____:______ AM/PM (Circle One) _____:______ AM/PM (Circle One)	Storage Requirements: ❑ None ❑ Refrigerate ❑ Other (please specify) ____________________________________ ____________________________________
Possible Side Effects:	Allergies (food, medications, other):

I give my permission to the school personnel to administer the medication listed above and am responsible for notifying the school if any medications change.

Signature of Parent/Legal Guardian: _________________________Date_____________

Phone Number: ________________________ Email: _____________________________

SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

Required for all prescription medications

Signature of Prescribing Healthcare Provider:___________________________________

Healthcare Provider Name (Printed): ____

Address: ____

Phone: ___________________________________Fax: ___________________________

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