Academy District 20

PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

TO BE COMPLETED BY HEALTH CARE PROVIDER
(FOR PRESCRIPTION or OVER-THE-COUNTER MEDICATION)

(Complete one form per medication: prescription or over-the-counter medication.)

Name of Student: _____ **Date of Birth:** _____

Medication: _____ **Reason for medication:** _____

Dosage: _____ **Route:** _____ **Time:** _____

Please list specific dosage, such as 2 tab/tsp/puffs every 4 hours, not a range such as 1-2 tab/tsp/puffs every 4-6 hours.

If 'as needed' (PRN), indicate when dose can be repeated: _____

Special Instructions: _____

Possible Side Effects: _____

Start Date: _____ **End Date:** _____

Name of Health Care Provider (print): _____ **Date:** _____

Signature of Health Care Provider with Prescriptive Authority: _____

Office Phone Number: _____ **Fax:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that whenever possible, medication should be administered at home. I understand that it is my responsibility to furnish the medication to school in the original labeled container marked with my child's name. Any prescription changes will require an additional signed and completed 'Permission to Administer Medication' form.

I give my permission for the school staff to contact the prescribing physician regarding this medication. I understand that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Academy District 20, the undersigned parent or guardian agrees to release Academy District 20 and its personnel from any legal claim which he, she or their child may now have or may hereafter have arising out of side effects or other medical consequences of the medication. I hereby give my permission for the student named above to take the above medication at school as ordered.

Name of Parent/Guardian (print): _____
Medicaid? No_____**Yes**_____ **Medicaid #** _____
Home phone: _____ **Other phone numbers:** _____
Signature of Parent/Guardian: _____ **Date:** _____

Revised: 4-27-2015