Medication Administration Permission Form
Prescription Medication

The completion of this form gives parental/guardian permission for the administration of listed medication during the time a child is at school. Only medication listed on this form shall be administered during the time the student is at school.
The bottom of this form must be completed and returned to the school office for your child to have medication administered at school. A legal prescriber's signature is **required** for administration of any prescription medication. The school shall have the right to contact the prescriber's office to confirm or clarify medication instructions. All medications shall be supplied to the school in the original container, properly labeled, and shall be administered only by personnel who have successfully completed a medication administration course (except in an emergency situation). A written medication administration record shall be on file at school. All medication shall be stored in a secure area unless an alternate provision is documented. Medication records shall be kept confidential.
The prescriber's signature is required on this completed form before any prescription medication will be given.
The medication must be kept in the school office unless otherwise authorized.
All medications must be kept in the original pharmacist's container. Containers must be properly labeled with the most current prescription in-formation. Prescription containers must include the following information: Name of medication, strength and quantity, dosage, prescription serial number, name and address of pharmacy, date prescription is dispensed, time to be given, name of doctor, name of student, and route of administration.
The time of medication administration may need to be altered slightly to fit your child's schedule. Please remind your child that she/he is responsible to go to the office at the appropriate time.
Medication will not be given if it has expired or it has an improper label. Please check the container before sending it to school.

Student Name: _____ Grade: _____ Home Room:_____

Name of Medication: _____ Strength: _____

Dosage:_____ Approximate time to be given at school: _____

Length of time medication is to be given (start and end dates_____

Health condition for which medication may be administered at school: _____

Prescriber's Name: _____

Prescriber's Signature_____

Name of Medication: _____ Strength: _____

Dosage:_____ Approximate time to be given at school: _____

Length of time medication is to be given (start and end dates_____

I request the above student be given the medication listed above at school. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know in order to provide appropriate services to this student. I understand the law provides that there shall be no liability for damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonably prudent person would under the same circumstances and that the school district and school staff are to incur no liability as a result of injury arising from the administration of medications.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____Date: _____

Home phone _____Work Phone_____ Cell Phone _____

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