YORK SCHOOL DISTRICT 1	**School Health Services Parent/Physician Request and Permission to Administer Medication at School**	**School Use Only:** ☐ Prescription ☐ Non-prescription Start Date:

Student Name:	Birthdate:
School:	Grade:

Is the student allergic to any food, medicines, or other items? ☐ No ☐Yes (if yes, list allergies)

Name of Medication to be given at school:	Dose of medication to be given:	
Time medication is to be given at school:	How often can medication be given? ☐ Daily ☐ As Needed	Route of medication administration: ☐ Oral ☐ Topical ☐ Inhalation ☐ Injection ☐ Other (please specify)
Reason for medication:	ICD-10:	Note any special storage requirements: ☐ None ☐ Refrigerate ☐ Other (please specify)
Anticipated length of time medication will be given at school: ☐ Until the end of the current school year ☐ _____weeks ☐ _____ days		
Possible side effects:		

****Physician's Signature is required for Prescription Medication****

_____ Prescribing Health Care Provider's Signature	_____ Date
Health Care Provider's Name and Address (please print):	Office Phone Number: Office Fax Number:

I understand that:

- **all medication must be brought to the school by a responsible adult in the original packaging or prescription bottle.**
- **the school may require that I agree to the school district's rules about medications before this medicine will be given at school.**
- **I am responsible for notifying the school if any of my child's medications change.**

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school nurse/principal designee to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school nurse/principal designee.

_____ **Signature of Parent/Guardian**	_____ **Date**
_____ **Print Name of Parent/Guardian**	_____ **Day Phone Number**