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

Please note the following:

1. Medication must be brought to the school nurse by a responsible adult. **(Do not send with a child.)**
2. Medication should be administered by a parent/guardian before or after school hours, when possible.
3. All prescribed medications must be provided to the school in a current, original labeled container issued by the pharmacist who filled the prescription and accompanied by this form, signed by parent and physician.
4. Starting doses of a medication that a child has never taken before should not be given first at school.
5. YSD1 may reject requests for certain medications to be given at school.
6. This form will apply if the student transfers to another school within YSD1.
7. Signing this form by parent and physician signifies agreement with Individualized Health Care Plan when applicable.

Student Name:	**Birthdate:**	**Grade:**
School:	**Homeroom Teacher:**	
Anticipated length of time medication will be given at school: ☐ Entire School Year and Summer School (if applicable) ☐ _____weeks ☐ _____ days	**Is the student allergic to any food, medicines, or other items?** ☐ No ☐Yes (if yes, list allergies)	

Medication to be given at school:		**Dose of medication to be given:**
ICD-10:	**Diagnosis:**	**Time medication is to be given:**
How often is the medication be given? ☐ Daily ☐ As Needed	**Route of administration:** ☐ Oral ☐ Topical ☐ Inhalation ☐ Injection ☐ Other (please specify)	
Note any special storage requirements: ☐ None ☐ Refrigerate ☐ Other (please specify)	**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 agree with all of the following:

• I give permission for my student to be given the above medication as prescribed while at school.
• I give permission for the YSD1 school nurse or designated YSD1 employee to contact the prescriber, the pharmacist who filled the prescription, or their designee to discuss this medication and my student's health.
• I give permission for the health care provider, pharmacist, and/or their designee to provide information about this medication and my student's health to the YSD1 school nurse or administrator.
• I further give permission for information about my student to be shared with persons who legitimately need to know for the safety and well-being of my student.
• I agree to follow the YSD1 rules concerning medications.
• I agree that the medication will be given per YSD1 policy.
• I agree I am responsible for providing school with the medication for my student and any supplies needed.
• I agree that I am responsible for notifying the school if my student's medication(s)/health status change in any way.

______________________________ ______________
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**