



**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:
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Time medication is to be given at school:	How often can medication be given? <input type="checkbox"/> Daily <input type="checkbox"/> As Needed	Route of medication administration: <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other (please specify)
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Reason for medication:	ICD-10:	Note any special storage requirements: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other (please specify)
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Anticipated length of time medication will be given:
 Entire School Year and Summer School (if applicable) _____ 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