

Student's Name: _____ Grade: _____

Medication

Medication: _____

Dose: _____

Time: _____

Special Procedures: _____

What it is for: _____

Medication: _____

Dose: _____

Time: _____

Special Procedures: _____

What it is for: _____

Allergies: _____

Parent Authorization

I, _____, request the above medication be administered to my child at school and school activities by qualified staff according to prescription or non-prescription instructions. My child has not experienced any previous reactions to this medication. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of the medication. I give my consent to contact or exchange pertinent information with my child's physician and/or specialist involved with their treatment of care as needed and that medication information may be shared with school personnel who need to know. I will send the medication in its ORIGINAL container. I agree to provide safe delivery of medication to and from school and to pick up remaining medication as needed. I have listed all of my child's allergies.

Parent/Guardian Signature

Date

Applies ONLY to Inhalers, EpiPens, and Insulin

PERMISSION TO CARRY MEDICATION AND SELF ADMINISTER MEDICATION

I, the undersigned legal parent/guardian of the above named child, verify the following and give permission for my child to carry medication:

My child recognizes the signs and symptoms that require the administration of the medication.

My child can administer the medication correctly.

My child will be responsible for carrying the medication on field trips.

My child will not share the medication.

Parent/Legal Guardian signature _____ Date _____

Physician signature _____ Date _____

School Nurse signature _____ Date _____