Permission for Prescription Medications

The Kinkaid School   School Year ______________

Parent or Guardian and Physician Signature Required

Student Name (Please Print):   DOB: Grade:

Parent Name: Phone Number:

Medication 1:____Taken with Food? ☐ YES ☐NO

Dosage: ___________________ Route: ________________Time of Administration: __________________

Medication 2: _______________________________________ Taken with Food? ☐ YES ☐ NO

Dosage: ___________________Route:_________________Time of Administration: _________________

Medication 3:____Taken with Food? ☐ YES ☐ NO

Dosage: ____________________Route:_________________Time of Administration: _________________

Inhaler:

Self-carry? ☐ YES ☐ NO   Self-administer? ☐ YES ☐ NO

I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, **I understand that a revised, written physician's statement and parent authorization must be uploaded to Magnus and communicated to the school nurse.**

**Parent/Guardian Signature: Date:

Physician or Nurse Practitioner Name (Please Print):   Phone:

**Physician or Nurse Practitioner Signature: Date:

***Signature is required for all medications unless prescribed for a short term, i.e. Amoxicillin for 10 days; pharmacy-labeled bottle will suffice.*

***All prescription medications must be in the most current bottle provided by the pharmacy.*