LEGACY EARLY COLLEGE
Elementary through College

"to and through college"

For school use only.
□ Routine
□ PRN (as needed)
Start Date:_____

Permission for School Administration of Prescription Medication

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before should not be given at school. Medication to be given at school should be accompanied by this form, completed with the prescribing physician's signature, and provided to the school in the original labeled container provided by the pharmacist who filled the prescription. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.

_____ _____ _____
Student's Name | Grade | Date of Birth

Is your child allergic to any food, medicines, or other items? ☐ No ☐ Yes (If yes, list allergies)

Medication:		Dosage:
Purpose of Medication:		Route:
Time medication to be given at school:	Frequency (i.e. daily)	Note any special storage requirements: ☐ Refrigerate ☐ None (*please specify*):
Possible Side Effects:		Estimated number of days medication will be given at school (choose one): ☐_____ days ☐_____ weeks ☐ until the end of the current school year
Stamp, Print or Type Health care Provider's Name, Address and NPI #:		Office phone number:

Physicians Signature:_____Date:_____

I give permission for my child to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the heath care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about the medication and my child's health to the school nurse or school administrator. I understand that the school may require that I agree to the school's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if my child's medications change in any way.

_____ _____
Signature of Parent/ Guardian | Date

_____ _____
Print Name of Parent/ Guardian | Day Phone Number

9/2020