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
Non-Prescription Medication

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits and according to the instructions printed on the container of the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school may reject requests for certain medications to be given at school.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

_____ _____ _____
Student's Name Grade Date of Birth

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

Name of medication to be given at school:		
Reason for medication:		
Amount of medication to be given:	Time of day medication to be given at school:	Possible side effects: Expiration date of medication:
Note any special storage requirements: ☐ Refrigerate ☐ Other (please specify)	Estimated number of days medication will be given at school (choose one): ☐ _____ days ☐ _____ weeks ☐ until the end of the current school year	
Child's Health care Provider's Name and Address (please print)		Office phone number:

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 or school administrator to contact the health care provider named above to discuss the 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 or school administrator. I understand that the school requires that I agree to the school's rules about medication before this medicine will be given at school. I understand that I am responsible for notifying the school if any of my child's medications change.

_____ _____
Signature of Parent/ Guardian Date

_____ _____
Print or Type Name of Parent/ Guardian Day Phone Number

9/2020