ESKENAZI HEALTH

Indianapolis, Indiana

CONSENT TO ADMINISTER PRESCRIPTIONS AND *PARENT-SUPPLIED* OVER-THE-COUNTER MEDICATIONS AT RIVERSIDE HIGH SCHOOL

ESKENAZI HEALTH

SCHOOL YEAR: _____

I, _____, hereby authorize the school healthcare office or designated personnel to

Parent/Guardian Name

give my child, _____, the medication(s) listed below.

Student's Legal Name

Child's Birthdate: _____ / _____ / _____ Grade: _____ Sex: _____ Race: _____

List all allergies: _____

Medication Name #1:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #2:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #3:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #4:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Print Name: _____

All prescription medications must be brought to the school healthcare office in the bottles or box that they were dispensed in from the pharmacy and with the original pharmacy label. Prescription medication will be dispensed as directed on the pharmacy label. If an antibiotic is prescribed by your doctor to be taken 3 times a daily, it is recommended that it be given before school, after school and at bedtime. This will maintain the level of medication in the body that is necessary for the best results, and you will not have to send the medication to school.

Over the counter (OTC) medications of any kind will not be given for more than 7 consecutive days. Please send only the amount that is needed at school for 7 days. All OTC medicines must be in the **ORIGINAL PACKING. Please LABEL CONTAINER** with your child's name, date of birth, parent's name and a phone number. Medications that are not sent to school in this manner cannot be given to your child. If a doctor has ordered OTC medication to be given daily or form more than 7 consecutive days, a prescription or the doctor's order MUST accompany this medication.

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ESKENAZI HEALTH

STUDENT'S LEGAL NAME _____ SCHOOL YEAR _____

Medication Name #5:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #6:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #7:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #8:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #9:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #10:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	
Medication Name #11:	**Dosage:**	
Time to be given at school: ____ AM ____ PM **PRN every ___ hours when _____**	**Start Date:**	**End Date:**
Physician's Name:	**Physician's Phone #:**	