



HERRON  
HIGH SCHOOL  
HERRON-RIVERSIDE  
HIGH SCHOOL  
HERRON  
PREPARATORY  
ACADEMY

CONSENT TO ADMINISTER PRESCRIPTIONS AND  
PARENT-SUPPLIED OVER-THE-COUNTER  
MEDICATIONS AT  
HERRON CLASSICAL SCHOOLS



SCHOOL YEAR: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the school healthcare office or designated personnel to  
give my child, \_\_\_\_\_, the medication(s) listed below.

Parent/Guardian Name

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 times per school year. Please send only the amount that is needed at school. 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, a prescription or the doctor's order MUST accompany this medication.



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ESKENAZI  
HEALTH

STUDENT'S LEGAL NAME \_\_\_\_\_

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 #:	