	Permission for School Administration of Prescription Medication **School District: OCSD**	**For school use only:** __ Routine __ PRN (as needed) **Start Date:_____**

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 complete 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 medication 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 and directions for administration.

This section to be completed by the prescribing health care provider:

_____ _____

Child's Name **Date of Birth**

_____ _____

Name of School **Grade**

Medication	**Dosage**	
Purpose of Medication (Diagnosis)	**Route**	
Time medication to be given at school (Lunch times vary 10:30am-1:00pm)	**Frequency (e.g., daily)**	**Note special storage requirements ____ None ___ Refrigerate ___ Other (please specify)**
Anticipated number of days medication will be given at school: ___ until end of current school year ___ week ___ days	**Is child allergic to any food, medicines, or other items? ____ No ___ Yes (List allergies) _____**	
Possible side effects:	**Is this medication a controlled substance? ____No ____Yes**	

_____ _____

Prescribing Health Care Provider's Signature **Date**

Stamp, Print, or Type Health Care Provider's Name & Address	**Office Phone Number** _____ **Office Fax Number**

This section to be completed by child's parent or guardian:

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 health 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 this medication and my child's health to the school nurse or school administrator. I also give permission for this "Permission for Prescription Medications" to apply if I transfer my child to another school in this same school district during the current school year. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I will not hold the school, school district, or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. 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 or Type Name of Parent/Guardian **Day Phone Number**