PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

District PASCO	School	Fax	Phone

Student: _____ **Birthdate:** _____ **Grade:** _____

PARENT/GUARDIAN SECTION * *SECCION DE PADRE/GUARDIAN*

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize administration of the medication identified below in accordance with the prescription and Health Care Provider's instructions (not to exceed one school year). **Medication will be in the original container.** This information may be shared with school personnel as needed for the well being of my child. *Yo dertifico que yo soy el padre/madre, tutor, u otra persona con control legal del susodicho estudiante y pido y autorizo la administración de la antedicha medicina de acuerdo con la receta o las instrucciones del médico (no exceder un año escolar).* ***La medicina estará en su envase original.*** *Esta información peude que sea compartida con personal de la escuela según la necesidad del bienestar de mi hijo/hija.*

_____	_____	_____
Parent/Guardian Signature *Firma de Padre/Guardian*	Date *Fecha*	Home phone / Emergency phone *Teléfono de Casa* *Teléfono de Emergencia*

---------- HEALTH CARE PROVIDER SECTION ----------

Medication Name **(only one medication per form)**	**Dosage**	**Route**	**Time / Frequency**

Diagnosis for which medication is to be given during school hours: _____

If PRN, signs or symptoms for which medication should be administered: _____

_____

*If given **prn**, specify length of time between doses:* _____

Other directions for use: _____

Possible side effects:_____Emergency Action:_____or ☐ 911

Self-Administration Permission: ☐ NO ☐ YES, I request the above-named student be allowed to have personal possession of or access to the medication which I have prescribed and be permitted to self-administer this medication in accordance with the prescription and instructions provided. Student understands proper use and storage of above medication. Non-scheduled medication only. Approval of school nurse. _____

Duration of Order (must choose one)

☐ Medication is ordered for duration of current school year (which may include summer school)
☐ Medication to be given from ____/____/____ to ____/____/____.

HCP Signature _____ Date _____

HCP Printed Name _____ Phone _____