MEDICATION ADMINISTRATION PERMISSION

Dear Parent/Guardian:

All medications, prescription, and OTC (over the counter) shall be administered only upon written order of the prescribing medical provider (M.D., D.O., APN, or PA) and written permission from the parent/guardian. This will give permission for the nurse to administer the medication as directed.

All medication must be given only to the school nurse in a currently labeled bottle or OTC labeled packaging matching the order specified by the medical provider.

TO BE COMPLETED BY THE MEDICAL PROVIDER

Student: _____ Date for administration: _____

Diagnosis/Purpose: _____

Name of Daily Medication/Dosage/Route/Frequency/Specify time (if applicable):

_____

_____

Name of PRN Medication -Special circumstances for administration and frequency:

_____

_____

Specify reportable side effects:

_____

_____

Medical Provider Signature: _____ Date: _____

Provider Stamp
with name,
address
and telephone #: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give permission to the school nurse to administer medication to my child as directed by the medical provider. I release school personnel of all liability for the administration of medication as specified above.

Signature of Parent/Guardian: _____ Date: _____