Child Name: _____ **Age:** _____ **Date of Birth:** _____

Completion of this form by the child's medical provider **and** parent/guardian is required for any mediations. We must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant to administer any medication, whether it is a prescription drug or over-the-counter medication. All prescribed medications must be delivered to the CCA in the original pharmacy labeled container. Any over-the-counter medications must be in their original packaging. **The first dose of a medication must be administered by the parent/guardian at home in case of an adverse reaction.**

Parent/Guardian:

By signing below, I give permission for the CCA staff and/or school nurse to contact the provider completing this form if further information or clarification is needed regarding the care of my child. By signing below, I also give permission to the CCA staff and/or school nurse to administer to or to supervise my child in taking the above medication. I understand that the school personnel are not responsible for any problems arising from the taking of this medication, its side effects (if any), or for the omission of medication. I further agree to indemnify and hold harmless the CCA and its agents and servants against all claims because of any or all acts performed under this authority.

Physician:

Physician Name: _____ Telephone: _____

Please complete and sign this form if the above-named child must take prescribed medication during school hours and it **cannot** be given at home:

Diagnosis: _____ Allergies: _____

Medication: _____ Dosage Prescribed: _____

Route: _____ PRN: Yes ( ) No ( ) Administration Time:_____

**This form will be valid for the school year in which it is dated unless specific dates are required.*

Date medication to begin: _____ Date medication to be discontinued: _____ N/A ( )

Special Instructions (if any):_____ Possible Side Effects (if any): _____

Required Signatures:

Physician: _____ Date: _____

Parent/Guardian: _____ Date: _____

For Office Use Only:

Medication will be routinely administered by: CCA Staff ( ) Minuteman Nurse ( )
Medication will be routinely stored: CCA Office ( ) Minuteman Health Office ( )

CCA Director: _____ Date: _____

Minuteman School Nurse: _____ Date: _____