

Advanced Math and Science Academy Charter School

Parent/Guardian Permission/ Medication Administration Plan (MAP) 2025-26

Student: _____	Parent/Guardian Name: _____
DOB: _____ Grade: _____	Home Phone: _____
Name of Licensed Prescriber: _____	Cell Phone: _____
Phone Number: _____	Parent/Guardian Name: _____
Emergency Contact; Name/Number: _____	Cell Phone: _____
_____	

Name of Medication: \_\_\_\_\_ Date of Medical Order ( received after July 1,2025)\_\_\_\_\_

Diagnosis: \_\_\_\_\_ Duration of Medication (Start Date/End Date): \_\_\_\_\_

Possible Side Effect/Adverse Reactions – Plan for monitoring student after admin if needed: \_\_\_\_\_

Allergies to Food or Medication:( Yes ( No Specify Allergy:\_\_\_\_\_

Other medications/supplements/herbals being taken by the student (if not in violation of confidentiality):\_\_\_\_\_

Location where medication administration will occur; (  Health Office (  Other; \_\_\_\_\_

Self-administered (Only For Insulin, Food Enzymes, EpiPen, Inhaler) (  Yes (  No\_\_\_\_\_

(  ) I understand that a parent/guardian must drop off medication to the school nurse and a 30-day supply is the maximum that can be stored at the school. It must be in it the original Pharmacy bottle with the appropriate label.

(  ) I give permission to the school nurse to administer the above medication to my child.

(  ) I give permission to the school nurse to share with appropriate school personnel the information relative to the prescribed medication as deemed necessary for my child's health and safety.

(  ) I request my child receive their medication at school prior to dismissal on Early Dismissal days.(Approx. 11:07am) (  Yes (  No

(  ) I request that my child receive their medication on Field Trips \*\*\*\* Please note a nurse is not always available for a field trip

Parent will attend if no nurse is available ?(  Yes(  No ; Student may receive medication upon their return (  Yes (  No (  ) make other arrangements\_\_\_\_\_

(  ) I understand that for this medication to be discontinued I need an updated medical note from the student's provider.

\*\*\*\*Please be aware that there is no availability for medication administration during after school activities other than staff is trained for EpiPen administration

Parent/Guardian Signature: \_\_\_\_\_ Date:\_\_\_\_\_

Student Signature (if appropriate): \_\_\_\_\_ Date:\_\_\_\_\_

FOR HEALTH OFFICE USE ONLY:

School Nurse Signature: \_\_\_\_\_ Date:\_\_\_\_\_

Date of Medical Order Received:\_\_\_\_\_ Quantity of Medication Received and Date: \_\_\_\_\_

Dosage:\_\_\_\_\_ Frequency:\_\_\_\_\_ Specific Time:\_\_\_\_\_ Route of Administration:\_\_\_\_\_ Expiration Date:\_\_\_\_\_

Required Storage Conditions: (  ) Unlocked(EpiPen, Inhaler, diabetic supplies (Baqsimi, Glucagon, Carbs), Cystic Fibrosis Enzymes

(  ) Locked cabinet (Valtoco/Diastat, ADHD, Rx Meds & OTC) (  ) Refrigerator locked at night/unlocked during school hours (Insulin) (  ) Other:\_\_\_\_\_

Disposal of medication: (  ) Finished (  ) Returned to parent/Guardian (  ) Given to Student Nurse Sig.:\_\_\_\_\_ Date:\_\_\_\_\_

(  ) Disposed- Witness: \_\_\_\_\_ Date: \_\_\_\_\_