HERRON HIGH SCHOOL

HERRON-RIVERSIDE HIGH SCHOOL

HERRON PREPARATORY ACADEMY

# CONSENT TO ADMINISTER PRESCRIPTIONS AND PARENT-SUPPLIED OVER-THE-COUNTER MEDICATIONS AT HERRON CLASSICAL SCHOOLS

**STUDENT'S LEGAL NAME: _____ SCHOOL YEAR: _____**

**List all allergies: _____**

_____

_____

*I hereby authorize the school healthcare officer or designated personnel to give my child the medication(s) listed below.*

**Parent/Guardian Signature: _____Date:_____**

**Parent/Guardian Print Name:_____**

***All prescription medications must be brought to the school healthcare office in the bottles or box that they were dispensed in from the pharmacy and with the original pharmacy label. <u>Prescription medication will be dispensed as directed on the pharmacy label.</u>*** *If an antibiotic is prescribed by your doctor to be taken 3 times daily, it is recommended that it be given before school, after school and at bedtime. This will maintain the level of medication in the body that is necessary for the best results, and you will not have to send the medication to school.*

***Over the counter (OTC) medications of any kind will not be given for more than 7 times per school year.*** *Please send only the amount that is needed at school.* ***All OTC medicines must be in the ORIGINAL PACKING. Please LABEL CONTAINER with your child's name, date of birth, parent's name and a phone number.*** *Medications that are not sent to school in this manner cannot be given to your child. If a doctor has ordered OTC medication to be given daily, a prescription or the doctor's order MUST accompany this medication.*

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|---|---|---|
| **Medication Name #1:** | **Dosage:** | |
| **Time to be given at school: _____ AM _____ PM**<br>**PRN every _____ hours when _____** | **Start Date:** | **End Date:** |
| **Physician's Name:** | **Physician's Phone #:** | |

| | | |
|---|---|---|
| **Medication Name #2:** | **Dosage:** | |
| **Time to be given at school: _____ AM _____ PM**<br>**PRN every _____ hours when _____** | **Start Date:** | **End Date:** |
| **Physician's Name:** | **Physician's Phone #:** | |

STUDENT'S LEGAL NAME: _____

| **Medication Name #3:** | **Dosage:** | |
|---|---|---|
| **Time to be given at school: _____ AM _____ PM**<br>**PRN every _____ hours when _____** | **Start Date:** | **End Date:** |
| **Physician's Name:** | **Physician's Phone #:** | |

| **Medication Name #4:** | **Dosage:** | |
|---|---|---|
| **Time to be given at school: _____ AM _____ PM**<br>**PRN every _____ hours when _____** | **Start Date:** | **End Date:** |
| **Physician's Name:** | **Physician's Phone #:** | |

| **Medication Name #5:** | **Dosage:** | |
|---|---|---|
| **Time to be given at school: _____ AM _____ PM**<br>**PRN every _____ hours when _____** | **Start Date:** | **End Date:** |
| **Physician's Name:** | **Physician's Phone #:** | |

| **Medication Name #6:** | **Dosage:** | |
|---|---|---|
| **Time to be given at school: _____ AM _____ PM**<br>**PRN every _____ hours when _____** | **Start Date:** | **End Date:** |
| **Physician's Name:** | **Physician's Phone #:** | |

| **Medication Name #7:** | **Dosage:** | |
|---|---|---|
| **Time to be given at school: _____ AM _____ PM**<br>**PRN every _____ hours when _____** | **Start Date:** | **End Date:** |
| **Physician's Name:** | **Physician's Phone #:** | |