Healthy Children Learn Better	**PERMISSION FOR SCHOOL ADMINISTRATION OF MEDICATION (Prescription)** Anderson 4 School District	For school use only: ☐ Routine ☐ PRN (as needed) Start date: _____

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never been taken before should be given at home by parent/guardian. Medication to be given at school should be accompanied by this form, complete with the physician's signature, and provided to the school in the original labeled over the counter or prescription container.

Student's Name _____ Date of Birth _____

Name of School _____ Grade/Teacher _____

Medication:		Dosage:
Purpose of Medication:		Route:
Time medication will be given at school (Lunch times vary 10:30 a.m. – 1:00 p.m.)	Frequency (e.g., daily)	Note special storage requirements ☐ None ☐ Refrigerate ☐ Other (please specify):
Anticipated number of days medication will be given at school: ☐ until end of current school year ☐ _____ weeks ☐ _____ days		Is child allergic to any food, medicines, or other items? ☐ No ☐ Yes (list allergies) Is this medication a controlled substance? ☐ No ☐ Yes
Possible side effects:		

Health Care Provider's Signature _____ Date _____ Telephone & Fax _____

Health Care Provider's Printed Name/Stamp _____

Section below to be completed by child's parent or guardian:

I give permission for my child, _____, to be given the above medication per physician order. Medication will be administered by the school nurse, or an unlicensed personnel trained by this nurse may assist in some cases. I give permission for the school nurse or other appropriate district personnel to contact the health care provider named above or the pharmacist to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or the designated employees to provide information about this medication and my child's health to the school nurse or other appropriate district personnel. I understand that I am responsible for notifying the school if my child's medications change in any way.

Signature of Parent/Guardian _____ Date _____ Daytime Contact Number _____

DATE MEDICATION WAS BROUGHT	AMOUNT IN CONTAINER	PARENT SIGNATURE	SCHOOL SIGNATURE