# High Point Academy

## Permission for School Administration of Medication

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 taken before should not be given at school. Medication to be given at school should be accompanied by this form, complete with the prescribing physician's signature, and provided to the school in the original labeled container. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name and directions for proper administration.

**This section to be completed by the prescribing health care provider:**

_____ _____
Child's Name Date of Birth

_____
Grade

| | | |
|---|---|---|
| Medication: | | Dosage: |
| Purpose of Medication: | | Route: |
| Time medication to be given at school (Lunch times vary: 10:30a – 1p) | Frequency (e.g., daily) | Note special storage requirements<br>□ None □ Refrigerate □ Other (please specify): |
| Anticipated number of days medication will be given at school:<br>□ until end of current school year<br>□ ____ weeks<br>□ ____ days | | Is child allergic to any food, medicines, or other items?<br>□ No □ Yes (List allergies.)<br><br>Is this medication a controlled substance? □ No □ Yes |
| Possible Side Effects: | | |

_____ _____
Prescribing Health Care Provider's Signature Date

| | |
|---|---|
| Stamp, Print or Type Health Care Provider's Name & Address: | |
| | Office Phone Number |
| | Office Fax Number |

**This section to be completed by child's parent or guardian:**

I give permission for my child, _____, to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I also give permission for this "Permission for School Administration of Medication" form to apply if I transfer my child to another school in this same school district during the current school year. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I will not hold the school, school district, or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. I will notify the school if my child's medications change.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Print or Type Name of Parent / Guardian Cell / Day Phone Number