Academy District 20

PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

TO BE COMPLETED BY HEALTH CARE PROVIDER
(FOR PRESCRIPTION or OVER-THE-COUNTER MEDICATION)

(Complete one form per medication: Prescription or Over-the-counter medication.)

Name of Student: _____ **Date of Birth:** _____

Medication: _____ **Reason for medication:** _____

Dosage: _____ **Route:** _____ **Time:** _____

If 'as needed' (PRN), indicate when dose can be repeated: _____

Special Instructions: _____

Possible Side Effects: _____

Start Date: _____ **End Date:** _____

Name of Health Care Provider (print): _____

Signature of Health Care Provider with Prescriptive Authority: _____

Office Phone Number: _____ **Fax:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request and give permission to Academy District 20 to administer medication to my child. ***I understand that whenever possible, medication should be administered at home.*** I understand that it is my responsibility to provide the medication in the original labeled container marked with my child's name. **Any prescription changes will require an additional signed and completed 'Permission to Administer Medication' form.**

I give my permission for the school staff to contact the prescribing physician regarding this medication. I release Academy District 20 and its staff from any claim which may arise out of the administration or failure to administer medication to my student.

Name of Parent/Guardian (print): _____
Medicaid? No_____**Yes**_____ **Medicaid #** _____
Home phone: _____ **Other phone numbers:** _____
Signature of Parent/Guardian: _____ **Date:** _____

Date Form Revised: 4/26/10