PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

School District	School	Fax	Phone

Student _____ **Birthdate** _____ **Grade** _____

PARENT/GUARDIAN SECTION

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions and give permission for the medication and care plan information to be shared with school staff on a "need to know" basis.

Yes ☐ ***No*** ☐

_____

Parent/Guardian Signature Date Home phone / Emergency phone

HEALTH CARE PROVIDER SECTION

Diagnosis for which medication is to be given during school hours: _____

Signs or symptoms for which medication should be administered _____

_____

_____ _____ _____ _____

Name of medication (1 per form): Dosage: Method of administration: Time of day to be given:

*If given **prn**, specify length of time between doses:* _____

Other directions for use: _____

Possible side effects: _____Emergency action: _____ ☐ 911

Duration of Order (must choose one)

☐ Medication is ordered for duration of current school year (which may include summer school)

☐ Medication to be given from ____/____/____ to ____/____/____.

_____ _____

HCP Signature Date

_____

HCP Printed Name

WASHINGTON PARK DIRECT CARE

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