ACADEMY

Medication at School

Student Name _____DOB_____

Medication, dose, number of times to be given daily:

_____

Take Medication: ☐by mouth ☐via inhaler ☐topical ☐injection ☐other_____

Reason for Medication:_____

Time(s) to be given: ☐Lunch ☐ As Needed ☐Scheduled time _____

Duration without subsequent order: Start (*date*)_____ End (*date*)_____

Medication Expiration Date: _____

Other medications student is taking: _____

Parent/Guardian's Permission:

I request that the school nurse or designated staff member be permitted to dispense as described the above medication to my child. The medication is to be brought to the nurse by me in the original container, labeled with my child's name. If notified by school personnel that medication remains after the course of treatment**, I will collect the medication from the school within five school days or understand that it will be destroyed. Medication is ordered to be given to a student at school only when necessary.** Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. Medications will not be scheduled to be given before 8:00 AM or after 2:30 PM. The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions. **Schedule II drugs (stimulants for ADD/ADHD) will not be sent on field trips.**

Parent/Guardian Signature: _____ Date: _____

Phone: _____

Over-the-counter medications that must be given during school hours may be kept and/or administered for up to *five* consecutive school days without a physician's order. If your child will require an OTC medication to be kept at school for a longer period, please have this form completed by your child's physician.

Health Care Provider's Signature: _____ Date: _____

Phone: _____Fax: _____