



## PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

### **PARENT/GUARDIAN SECTION \* SECCION DE PADRE/GUARDIAN**

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. *Yo pido que la enferma o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del médico y entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.*

Yes \_\_\_\_\_ No \_\_\_\_\_  
Sí \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature  
*Firma de Padre/Guardian*

\_\_\_\_\_  
Date  
*Fecha*

\_\_\_\_\_  
Home phone  
*Teléfono de Casa*

\_\_\_\_\_  
Emergency phone  
*Teléfono de Emergencia*

### **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 (as needed), specify length of time between doses:*

\_\_\_\_\_  
Other directions for use: \_\_\_\_\_ Possible side effects \_\_\_\_\_

Emergency Action: \_\_\_\_\_ or  911    Child can self-administer? \_\_\_\_ Yes \_\_\_\_ No

#### **Duration of Order (must choose one)**

- Medication is ordered for duration of current school year until \_\_\_\_\_ (last day of school)  
 Medication to be given from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ .

\_\_\_\_\_  
HCP Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
HCP Printed Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Date