Parent/Guardian
Medication Permission Form

Parent or Guardian: If your child *requires* medication during the school day, the following guidelines must be observed:

1. This signed and completed permission form must be on file (***for each medication***) in the school office. An explanation of the necessity for the prescribed medication to be administered during the school day must be completed (see * below).
2. **No over-the-counter (non-prescription) medication will be administered to students without a written statement from their physician or dentist indicating the necessity.**
3. The school office must be promptly notified of any changes in the medication regimen.
4. All medications must be stored and administered according to school policy.
5. The student is responsible for coming to the office at the appropriate time for the medication.
6. All medication must be in a properly labeled container either from a pharmacy (prescription), or from the manufacturer of the medication. Ask your pharmacist for a duplicate prescription container for use at school.

Consent: As legal guardian, I hereby authorize _____ (child) to take the medication that I will provide, and that is listed in the medication profile, and further authorize the school to store the medication according to school policies, and assist with administration of the medication as directed. I further agree to inform the school of any changes in the medication, including changes in when the medication is taken, changes in the dose, new or different medication, a reaction to the medication, or discontinuation of medication. I further understand that this consent applied to all medication, whether prescribed by a physician, or purchased over the counter without a prescription. I understand that this consent applies for this school year only, and next year I am required to sign another consent form.

Parent/Guardian Signature: _____ Date: _____

Medication Name: _____			
* Please explain the necessity of administering the medication during the school day.			
List the diseases or conditions being treated:			
List your child's allergies:			
How long will your child need this medication?			
How does your child prefer to take medication (i.e., with water, in a cup, sitting down, by themselves, with help)?			
Physician name:		Phone:	

Time of Day to be Taken or As Needed for _____)?	Dose of Medication (One Tablet, 2 Puffs, 1 Teaspoonful, 3 Drops, Etc.)?	To be given….by mouth, inhaled, drops in ear, etc.	Does Student Administer this Medication Themselves (yes/no)?	Medication Requires Refrigeration?	Please list any side effects/complications of this medication.

Please list any further instructions or pertinent information regarding your child and their medication: _____

Student Name:	

Student Medication Administration Record

Medication:

	Month:																				Year:										
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time																															
Dose																															
Initials																															
	Month:																				Year:										
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time																															
Dose																															
Initials																															
	Month:																				Year:										
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time																															
Dose																															
Initials																															

Signature and initials of person authorized to administer medication:	

If medication is not given, use codes listed below:	
A =	Absent
ED =	Early Dismissal
FT =	Field Trip
NA =	Med. Not Available
NS =	No Show

Student:		Grade:	