Centennial BOCES
Medication Administration Permission in School

The parent/guardian of _____ gives permission to school staff to give this

Medication _____ Dose _____ at Time(s)_____

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The school agrees to administer only medication prescribed by a licensed health care provider.
It is the responsibility of the parent/guardian to furnish the medication.
Medication may NOT be transported by the child or placed in the child's backpack for transport to and from school.
The parent or guardian agrees to pick up expired or unused medication within one week of notification by staff.

Prescription Medications: Must come in the original container labeled with: child's name, name of medicine, frequency the medication is to be given, dosage, date the medication was ordered and is to be stopped, licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the Counter Medication: **A licensed professional must also prescribe over the counter medication.** The container must be labeled with the child's name. The dosage must match the signed health care provider authorization and the medicine must be packaged in the original container.

By signing this document, I agree to the above and give permission for my child's health care provider to share information about the administration of this medication with the nurse and school staff delegated to administer medication.

Parent/Guardian Signature: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Health Care Provider Authorization to Administer Medication in School

Child's Name: _____ Birth date: _____

Medication: _____

Dosage: _____ Route: _____

To be given at the following time(s): _____

Special instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

_____

Starting Date: _____ Ending Date: _____

Signature of Health Care Provider: _____ Date: _____
(With Prescriptive Authority)

Phone Number: _____

***Please ask the pharmacist for a separate medicine container to keep at school.**