Montessori School of Anderson

Permission for School Administration of Prescription Medication

Healthy Children Learn Better

For school use only:
□ Routine
□ PRN (As needed)
Start Date: _____

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before should not be given at school. Medication to be given at school should be accompanied by this form, complete with the prescribing physician's signature, and provided to the school in the original labeled container provided by the pharmacist who filled the prescription. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

_____ Student's Name	_____ Grade	_____ Date of Birth	_____ Homeroom Teacher

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day medication to be given at school: If possible, please specify preferred time. Lunch times vary (10:30a – 1p).	Note any special storage requirements: □ None □ Refrigerate □ Other (please specify):
Anticipated number of days medication will be given at school: □ until end of current school year □ ____ weeks □ ____ days	Is child allergic to any food, medicines, or other items? □ No □ Yes (List allergies.)
	Is this medication a controlled substance? □ No □ Yes
Possible Side Effects:	

_____ Prescribing Health Care Provider's Signature

_____ Date

Stamp, Print or Type Health Care Provider's Name & Address:	Office Phone Number:
	Office Fax Number:

Section below to be completed by child's parent or guardian:

I give permission for my child, _____, to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator I understand that I am responsible for notifying the school if my child's medications change in any way.

_____ Signature of Parent / Guardian

_____ Date

_____ Print or Type Name of Parent / Guardian

_____ Day Phone Number