SUMMIT ACADEMY NORTH

Permission Form for Prescribed Medication

School: _____ Date form received by the school: _____

Student: _____ Date of Birth: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:
☐ Tablet/capsule ☐ Liquid Inhaler ☐ Injection ☐ Nebulizer ☐ Other: _____

Time and Dose to be given at school: _____

If p.r.n., list symptoms/conditions under which medication is to be given: _____

_____

_____

Special Instructions: _____

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes, please describe:

_____

Special storage requirements: ☐ None ☐ Refrigerate

Start: ☐ Date form received ☐ Other dates: _____
Stop: ☐ End of school year ☐ Other date/duration: _____

Physician's name: _____

Address: _____

Phone Number: _____ Fax: _____

Physician's signature: _____ Date: _____

Physician's Stamp

To be completed by parent/guardian

I request that (name of child) _____ receive the above medication at school according to standard school policy and for the physician staff and school staff to share information needed to assist my child with his/her health and medication needs.

Parent/Guardian signature: _____

Relationship to student: _____ Date: _____

Medication Prescriber/Parent Authorization Form

for Self-Administration/Self-Possession

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration. Self-administration medication is limited to inhalers & insulin pumps only. The school district recommends that spare medication, properly labeled in its original container, be kept in the clinic/office in case the student runs out or forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian. The student must carry a copy of this form at school.

Student Name:_____ Birth Date:_____ School Year:_____

To be completed by physician/licensed prescriber:

Start Date:_____ Stop Date:_____

Medication name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions

*Routes: oral (pill/capsule/chewable, liquid) ~inhaled (inhaler, nebulizer) ~topical (eye/ear drop, ointment, etc.) ~injection ~other (list)

List minimal frequency between doses (especially if p.r.n):_____

If p.r.n., list symptoms/conditions under which medication is to be given:_____

The student is capable of ☐ self-administering ☐ self-possessing the above medication(s)

_____ _____ _____

Physician's signature Date Physician's printed name

Physician's phone #:_____ Fax:_____

Address:_____

To be completed by parent/guardian:

I request and give permission for my child (named above) to: self-administer self-possess the above medication according to school district policy and for the physician staff and school staff to share information regarding my child's health and medication needs.

_____ _____

Parent/guardian signature Date

To be completed by student:

I agree to:

1. Never share my medication with another person.
2. Carry the medication in its original, properly labeled prescriptive/over the counter container.
3. Take medication only at the prescribed time/frequency and dose.
4. Keep a copy of this form and back up medication in the school office/clinic.

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardians, and the privilege(s) of self-administration/self-possession denied.

_____ _____

Student signature Date