

## Permission for Medication

“All Medications shall be administered to a child only on the written, dated, and signed release. The original label on the container with the instructions is acceptable.”

“Prescription medications will be in the original container labeled with the child’s name, date, instructions and the physician’s name.”

“All non-prescription medication will be labeled with the child’s name and dated.”

Above are some standards regarding the administration of medication to children in school. Please help us comply with these standards by sending medicines in the appropriate container if your child requires medication during school. It is imperative that the attached form be filled out by the parent or guardian and returned to school with the medication. If anything changes during the year please let us know immediately.

A daily log will be kept in the school office to record the date and time that the child received the medication.

**PLEASE DO NOT PUT ANY MEDICATION IN YOUR CHILD’S LUNCH BOX OR BOOK BAG.**

Thank you,

Chana Goldstein RN CPNP  
ATT School Nurse Consultant

**Authorization and Permission for Administration of Medication**

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

School: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time to be given: \_\_\_\_\_

Dates to be given: \_\_\_\_\_

Other medications child is taking \_\_\_\_\_

Expected side effects, if any \_\_\_\_\_

Any precautions while taking this medication \_\_\_\_\_

Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student may / may not self-administer medication with supervision. (please circle one)

Doctor's Name: \_\_\_\_\_ Doctor's Number: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

**\*Doctor's Signature:** \_\_\_\_\_

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize \_\_\_\_\_ (name of school) and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school or school district, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the school, school district, employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

**\*Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Phone Number to Reach a Parent or Guradian: \_\_\_\_\_