Pinewood PREPARATORY SCHOOL	**Permission for School Administration of Medication** School Year:_____	**For school use only:** □Routine □PRN (as needed) □Self-administer

To be completed by parent/legal guardian:

Student Name: _____ Date of Birth: _____
Grade_____ Home Room Teacher: _____

Is child allergic to any food, medicines, or other items? □No □Yes (If yes, list allergies.) _____
_____

Does your child take any other medications at home or at school? □No □Yes (please list) __
_____

Name of Health Care Provider: _____
Office Phone: _____ Office fax: _____

I give permission for the medication listed below to be given to my child as prescribed during the school day. 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/legal guardian: _____ **Date:** _____
Print Name of Parent/guardian: _____ **Phone:**_____

I would like my child to be considered to self-administer the above medications. Only **epi-pens**, **inhalers** or **special medications by nurse approval** may be self-administered. Controlled substances are never considered for self-administration. □ Yes □ No □ N/A

To be completed by physician/legal prescriber:

Medication:	Dosage:
Reason for medication:	Route:
Time medication to be given at school:	How often can medication be given?
Anticipated number of days medication will be given at school (choose one): □ until end of school year □ _____weeks □ _____days	Special storage requirements: □ None □ Refrigerate □ Controlled substance
Possible Side Effects:	

Physician/Legal Prescriber Signature_____ **Date:** _____
Physician/Legal Prescriber, print name/title_____