Permission to Dispense Over-The-Counter Medication

Student Services

Student information

Student's first name _____ Middle name _____ Last name _____

School _____ Grade _____ School year _____ Birth date _____

Is student allergic to any food, medicines or other items? ☐ No ☐ Yes (List allergies) _____

By signing this form, I understand that (Check each item to indicate you understand)

- ☐ Medications should be administered by a parent/guardian before or after school hours, when possible.
- ☐ Initial dose of a medication that the student has never taken before should **NOT** be given at school.
- ☐ Medication to be given at school must be accompanied by this form.
- ☐ Medication must be given to the school in the original labeled container.
- ☐ Over-the-counter medications may only be given according to limits and instructions printed on container or package insert.
- ☐ A separate form for each medication to be given at school.
- ☐ A separate form for each child must be submitted, even if more than one of your children needs the medication at school.

Medication information

Medication name _____ Dosage _____ Frequency _____ Time to be given at school _____

Route: ☐ By mouth ☐ By injection ☐ Other _____ **Is this medication a controlled substance?** ☐ No ☐ Yes

Anticipated number of days medication will be given at school: ☐ Rest of school year ☐ _____ days ☐ _____ weeks

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Purpose of medication: _____ **Possible side effects:** _____

Health care provider information

Print health care provider's name _____ Office phone _____ Office fax number _____

Address _____ City _____ State _____ Zip _____

Permissions (Check each item to indicate you understand)

- ☐ I give permission for my child, named above, to be given the above medication as prescribed.
- ☐ I give permission for the school nurse 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, principal and/or his/her designee.
- ☐ I give permission for this "Permission to Dispense Prescription Medication" to apply if I transfer my child to another school in our district during the current school year.
- ☐ I understand the school will require that I agree to district rules about medications before this medicine will be dispensed.
- ☐ I understand that I am responsible for notifying the school if my child's medications change in any way.

Printed name of parent/guardian _____ Signature of parent/guardian _____ Daytime phone _____ Date _____

Permission to Dispense Prescription Medication

Student Services

Student information

Student's first name _____ Middle name _____ Last name _____

School _____ Grade _____ School year _____ Birth date _____

Is student allergic to any food, medicines or other items? ☐ No ☐ Yes (List allergies) _____

By signing this form, I understand that (Check each item to indicate you understand)

- ☐ Medications should be administered by a parent/guardian before or after school hours, when possible.
- ☐ Initial doses of a medication that the student has never taken before should NOT be given at school.
- ☐ Medication to be given at school must be accompanied by this form.
- ☐ Medication must be given to the school in the original labeled container from 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. The note must include the student's name, directions for proper administration and the name, address and phone number of the prescribing health care provider.
- ☐ A separate form for each medication to be given at school.
- ☐ A separate form for each child must be submitted, even if more than one of your children needs the medication at school.

Medication information

Medication name _____ Dosage _____ Frequency _____ Time to be given at school _____

Route: ☐ By mouth ☐ By injection ☐ Other _____ Is this medication a controlled substance? ☐ No ☐ Yes

Anticipated number of days medication will be given at school: ☐ Rest of school year ☐ _____ days ☐ _____ weeks

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Purpose of medication: _____ Possible side effects: _____

Health care provider information

Print health care provider's name _____ Office phone _____ Office fax number _____

Address _____ City _____ State _____ Zip _____

Permissions (Check each item to indicate you understand)

- ☐ I give permission for my child, named above, to be given the above medication as prescribed.
- ☐ I give permission for the school nurse 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, principal and/or his/her designee.
- ☐ I give permission for this "Permission to Dispense Prescription Medication" to apply if I transfer my child to another school in our district during the current school year.
- ☐ I understand the school will require that I agree to district rules about medications before this medicine will be dispensed.
- ☐ I understand that I am responsible for notifying the school if my child's medications change in any way.

Printed name of parent/guardian _____ Signature of parent/guardian _____ Daytime phone _____ Date _____