Medication Administration
Permission for School and Child Care

The parent/guardian of_____
CHILD'S NAME
ask that the school staff give the following medication
_____at_____
NAME OF MEDICINE AND DOSAGE TIME(S)
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.
Prescription medications must come in a container labeled with all of the following: (1) child's name, (2) name of the medicine, (3) time the medicine is to be given, (4) dosage, (5) discard date, (6) licensed health care provider's name, (7) pharmacy name, and (8) pharmacy phone number.

Over-the-counter medications must be labeled with the child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in the original container.

Ascent Classical Academy agrees to administer medications prescribed by a licensed health care provider with prescriptive authority. The parent agrees to pick up the expired or unused medication within one week of notification by staff. All medication(s) left at the school will be discarded according to the most current state regulatory recommendation for safe medication disposal.

By signing this document, I give permission for my child's health provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____
PARENT/GUARDIAN PRINTED NAME PARENT/GUARDIAN SIGNATURE

_____ _____
DATE PHONE NUMBER

Health Care Provider Authorization

Child's Name: Birthdate:_____ Medication:_____
Dosage/Route:_____ Time(s):_____
Starting Date:_____ Ending Date:_____
Purpose of medication:_____
Special Instructions including side effects to be reported:_____
_____
Signature of Health Care Provider:_____License #:_____
Print Name of Health Care Provider:_____ Date:_____
Phone:_____

FOR SCHOOL USE ONLY: MEDICATION VERIFICATION CHECKLIST

Delegating RN Signature: _____
Delegated Health Tech Signature :_____