SUMMER 2019 EXPLORATIONS

Permission for Prescription Medications

Summer Explorations
*Parent or guardian and **physician signature** required*

Student Name _____ Date of Birth _____

Parent Name _____

Current medications child takes including drug name, dosage, route, time(s) of day and if taken with food. Are these medication(s) to be administered at school? ❑ Yes ❑ No

Medication 1: _____ Taken with food? ❑ Yes ❑ No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? ❑ Yes ❑ No Self-administer? ❑ Yes ❑ No

Medication 2: _____ Taken with food? ❑ Yes ❑ No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? ❑ Yes ❑ No Self-administer? ❑ Yes ❑ No

Medication 3: _____ Taken with food? ❑ Yes ❑ No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? ❑ Yes ❑ No Self-administer? ❑ Yes ❑ No

If yes, I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent authorization must be submitted.

Parent/Guardian Signature _____ Date _____

Physician or Nurse Practitioner Name _____ Phone _____

Physician or Nurse Practitioner Signature _____ Date _____

***Signature is required for all medications unless prescribed for a short term. i.e. Amoxicillin for 10 days; pharmacy-labeled bottle will suffice.*