

**PERMISSION FOR NON-PRESCRIPTION MEDICATION\***

\_\_\_\_\_  
Child's Name/DOB

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Date

- The school nurse must have this **completed form** before medication will be given at school.
- An **adult** must bring the medication to school.
- Medication must be in the original **manufacturer's container**. Loose medication in plastic bags will not be accepted.
- The school nurse must approve and administer the **first dose** of any medication given at school.
- The school nurse may delegate administration of subsequent doses to another school staff member.
- All medicine must be **kept in the nurse's office**.

I give permission for the medication below to be given to my child at school by the school nurse or her designee.

Medication \_\_\_\_\_

Dosage/Route/Time \_\_\_\_\_

Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Reason medication is being given \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

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Date Received \_\_\_\_\_ Signature of School Nurse \_\_\_\_\_

**\*non-prescription medication will only be administered according to manufacturer's label or prescription medication order and permission form will be necessary\***

**PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM**

- The **school nurse *must*** have this **completed form** before medication will be given at school.
- The school nurse must approve and administer the **first dose** of any medication given at school.
- The school nurse may delegate administration of subsequent doses to another school staff member.
- A **parent/adult** must bring the medication to school in an **appropriately labeled pharmacy container**.
- All medicine must be **kept in the nurse's office** unless the health care provider, parent and administrator have given permission for the student to keep the medication for self-administration.

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Name of Child/DOB \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

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**Medication Order:**

Medication \_\_\_\_\_ Strength \_\_\_\_\_

Dosage/Route/Time \_\_\_\_\_

Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Reason for medication \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_

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**Parent's permission for:**

- Health care provider may share information

I give permission for \_\_\_\_\_ to share information with  
Healthcare provider

School nurse/s, \_\_\_\_\_ RN, concerning my child's medication(s).

- Medication to be given at school

I give permission for the medication prescribed above to be given to my child at school by the school nurse or nurse's designee.

Parent or Guardian Signature \_\_\_\_\_

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