

# PCM Community School District Medication Administration Permission Form

## ADMINISTRATION OF MEDICATION TO STUDENTS

1. To maintain the safety of all students a responsible adult will transport medication to & from school.
2. Medication will be supplied in the original prescription bottle or manufacturer packaging and will be correctly labeled.
3. Expired or improperly labeled medication will not be given. (Medications are not provided by the school)
4. The first dose of a medication should be given at home. (With the exception of emergency relief medications)
5. A parent or legal guardian must provide written authorization for medication administration.
6. This consent is only good for the current school year.

**This form must be completed and returned to the health office before medication will be administered at school.**

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Medication:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_ **Time Given:** \_\_\_\_\_

**Beginning Date:** \_\_\_\_\_ **Discontinued Date:** \_\_\_\_\_

**Diagnosis / Reason for Medication (Optional):** \_\_\_\_\_

**Prescriber's Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_ (For Prescription Medication ONLY)

**Late Start Days:** I will give medication at home \_\_\_\_\_ Please give medication at school \_\_\_\_\_

**Early Dismissal:** Please give medication at school \_\_\_\_\_ Child will take medication at home \_\_\_\_\_

**Special instructions:** \_\_\_\_\_

It is necessary for my child to be given medication during school hours. I give my permission for the school nurse, or designee to administer the medication listed above. I agree that the student has experienced no previous side effects from the medication. I further understand that it may be in my child's best interest for the health staff to share this medication information with other school staff (teacher, counselor, etc. as necessary) and give permission to do so if needed. The school nurse has my permission to contact the prescribing physician if necessary.

**Parent/Guardian Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*SIGNATURE:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

## **IF THERE IS UNUSED MEDICATION AT THE END OF THE SCHOOL YEAR: (Please check one)**

\_\_\_\_\_ I will pick up any remaining medication at the end of the school year.

\_\_\_\_\_ Please dispose of any remaining medication on the last day of school.

**\*Parent/Guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*  
**SELF-ADMINISTERED AND POSSESSION OF MEDICATIONS**

*(3<sup>rd</sup> – 12<sup>th</sup> GRADE SEVERE ALLERGY/ASTHMATIC/DIABETIC STUDENTS ONLY)*

### **Epipen, Inhaler and/or Insulin injections ONLY**

I request authorization for my child to self-administer the above medication. I verify he/she is capable and responsible for self-administering the medication:

\_\_\_\_\_ With Assistance                      \_\_\_\_\_ Without Assistance

**\*Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Epipen, Inhaler and/or Insulin injections ONLY**

I request authorization for my child to have possession of the above medication. I verify he/she is capable and responsible for having possession of this medication:

**\*Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_