PARNASSUS
PREPARATORY SCHOOL
Classical Schooling for the Art of Life

Medication Administration Authorization

* One Medication per Form

The Parent/Guardian of _____ *ask that Parnassus Preparatory School Health Service Staff*
(Child's Name)

to give the following medication _____ *at* _____
(Name of Medicine and Dosage) *(Time(s) of Day)*

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

- The School agrees to administer medication prescribed by a licensed health care provider.
- It is the parent/guardian's responsibility to furnish the medication and proper measuring device(s).
- The parent agrees to pick up expired or unused medication within one week of notification by staff.
- ***Prescription*** medications must be provided in a labeled container by Pharmacist/Physician with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped (if appropriate), and licensed health care provider's name. Pharmacy name and phone number must also be included on label.
- ***Over the Counter*** medications must be labeled with child's name and packaged in the original container. Dosage must match the signed licensed health care provider authorization.

Please ask the Pharmacist for a separate medicine container to keep at the School

I give permission, by signing this document, for my child's health care provider to share information about the administration of this medication with the School Nurse or delegated school staff who will be administering this medication.

_____ _____ _____
Parent/Guardian's Name *Parent/Guardian Signature* *Date*

_____ _____ _____
Work Phone *Home Phone* *Cell Phone (if applicable)*

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Health Care Provider Authorization to Administer Medication During School Hours

Child's Name: _____ Birth Date: _____

Medication: _____ Dosage: _____ Route: _____

To be given at the following time(s) in School: _____

Special Instructions: N/A or _____

Purpose of Medication: _____

Side effects which need reporting: N/A or List: _____

Starting Date: _____ Ending Date: N/A or: _____

Name of Health Care Provider Ordering Medication: _____

_____ _____
Name of Medical Facility *Phone Number*

_____ _____
Signature of Authorizing Health Care Provider *Date*