

Medication Administration Authorization

* One Medication per Form

The Parent/Guardian of	a	sk that Parnassus Preparatory School Health Service Staff	
	(Child's Name)		
to give the following medication	at		
	(Name of Medicine and Dosa	ge) (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 Signa	ature	Date	
Work Phone	Home Phone		Cell Phone (if applicable)	
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Health Care Provider Authoriza	ation to Administe	er Medicatio	n During School Hours	
Child's Name:	В	rth Date:		
Medication:	Dosage:	Rout	e:	
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 Medicatio	n:			
Name of Medical Facility			Phone Number	
Signature of Authorizing Health Care Provider			Date	