Prescription Medication
Permission for School Administration

This form must be completed annually by the child's prescriber and parent/legal guardian.

Please note the following:

1. Medication must be brought to the school nurse by a responsible adult. (Do not send with a child.)
2. Medication should be administered by a parent/guardian before or after school hours, when possible.
3. All prescribed medications must be provided to the school in a current, original labeled container issued by the pharmacist who filled the prescription and accompanied by this form.
4. Starting doses of a medication that a child has never taken before should not be given first at school.
5. BCSD may reject requests for certain medications to be given at school.
6. This form will apply if the child transfers to another school within BCSD.

Child's Full Name:		**Date of Birth:**	**Gender:** □ Male □ Female
Grade:	**Homeroom Teacher:**	**Name of School:**	
Section below must be completed by the Child's Health Care Provider:			
Name of Prescribed Medication:		**Purpose for Medication:**	
Prescribed Dose:	**Prescribed Route:**	**Controlled Substance:** □ No □ Yes	**Special Storage Required:** □ No □ Yes _____
Time of day Medication is to be given at school: (Please specify preferred time. "Lunch" times vary from 10:30am-1:30pm)		**Number of days medication will be given at school:** □ until the end of the current school year □ _____ day(s) □ _____ week(s)	
List possible side effects from this medication:			
Does this child have any known allergies? □ No □ Yes (If yes, list all known allergies and reactions)			
Child's Health Care Provider's Name and Office Address (print or stamp):			

Office Phone: _____

Office Fax: _____

_____ _____

Health Care Provider's Signature **Date:**

Section below must be completed by the Parent/Legal Guardian:

I agree with all of the following:

- I give permission for my child to be given the above medication as prescribed while at school.
- I give permission for the BCSD school nurse or designated BCSD employee to contact the prescriber, the pharmacist who filled the prescription, or their designee to discuss this medication and my child's health.
- I give permission for the health care provider, pharmacist, and/or their designee to provide information about this medication and my child's health to the BCSD school nurse or administrator.
- I further give permission for information about my child to be shared with persons who legitimately need to know for the safety and well-being of my child.
- I agree to follow the BCSD rules concerning medications.
- I agree that the medication will be given per BCSD policy.
- I agree I am responsible for providing school with the medication for my child and any supplies needed.
- I agree that I am responsible for notifying the school if my child's medication(s) change in any way.

_____ _____ _____ _____

Parent/Guardian's Name (Print) **Parent/Guardian's Signature** **Date** **Daytime Phone**