



Medication Permission Form JK-8th Grade Students

Student's Name: _____ Date of Birth: _____ School: _____

Medication Information:

Check ONE		Medication Name	Dose/How much to give: List mg, mcg, or other measurement	When to give: Ex: "at lunch," "2pm," or "every 4 hours for pain"
Daily	As Needed			

Over the counter medications (such as tylenol, benadryl, or ibuprofen) do not need a medical provider's signature. All prescription medications including epipens and inhalers must have a medical provider's signature.

TO BE COMPLETED BY MEDICAL PROVIDER (if prescription medications are listed above)

Practitioner Printed Name: _____ Phone: _____

Clinic/Health care system: _____ Fax: _____

Practitioner Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give consent for school personnel to administer medication as described above. I authorize communication between the prescribing health care provider, the school nurse, and trained school personnel necessary for the management and administration of this medication. I have read the procedures outlined in board policy 5330 and assume responsibilities as required.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL STAFF:

Verify all when medication is delivered to school:

- ☐ All above information is completed, including signatures.
- ☐ Medication is in original packaging with clear dosing instructions/prescription label.
- ☐ Written instructions above match written instructions on medical packaging.

Staff signature: _____ Date: _____