First State Montessori Academy

MEDICATION PERMISSION FORM

COMPLETE A SEPARATE FORM FOR EACH MEDICATION

If it is necessary for your child to receive prescription/non-prescription medication or treatment during the school day, or while on a school-related field trip, please communicate this to the School Nurse and do the following:

- Send the medication to school with a responsible individual, if you are unable to bring it to school. **If the medication is a CONTROLLED SUBSTANCE, it must be handed directly to the nurse by an adult, 18 years of age or older.**
- Send the medication in the original container. It must be properly labeled with the pharmacy prescription label and state the student's correct name, time, dose and method of administration. The nurse is required by law to follow the prescription instructions as written on the medication label.
- Count the number of tablets or estimate the amount of liquid in the bottle.
- Fill out the following information on this form:

Today's Date: _____

Student's Name: _____**Room #**: _____**Grade**: ____

Name of Medication: _____**Dose amount**: _____

Time of Dose: _____**Reason for Medication**: _____

Allergies to Medications: _____

Number of Tablets/Amount of Liquid Sent: _____ **Expiration Date**: _____

- I am aware that the School Nurse may need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and I give my permission for the Nurse to do so.
- I give permission for my child to receive this medication when taken off of school premises for field trips or other activities. I understand that a trained staff member will *assist* my child with medications when given off of school premises (unless specified by the nurse).
- I give permission for remaining medication to be sent home with my child in his/her backpack at the end of the school year **UNLESS** I notify the Nurse that I will pick it up from the Nurse's Office (does not apply to controlled substances).

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Nurse Signature: _____

Number of tablets/Amount of liquid received: _____

Complete back of page for medication refills.

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Medication Refills

Date Refill Received	# of Tablets/Amt of Liquid	Nurse Signature	Parent Signature