



School Year:  
20\_\_ - 20\_\_

# SPRINGDALE PREPARATORY SCHOOL MEDICATION ADMINISTRATION PERMISSION FORM

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ GRADE: \_\_\_\_\_

Medications administered to students at school or on school-sponsored trips will require specific directions from your child's health care provider. If it is necessary to administer medications to your child, orders from your child's health care provider are required. Medications will be provided by parents/guardians in the original container. Prescription medications must have the current prescription label on the medication.

**TO BE COMPLETED BY PHYSICIAN**

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Purpose of Medication \_\_\_\_\_

Route \_\_\_\_\_ Time medication is to be given \_\_\_\_\_

Possible side effects \_\_\_\_\_

Signature of Prescribing Health Care Provider \_\_\_\_\_

Date \_\_\_\_\_

Printed Name of Provider \_\_\_\_\_

Provider's Office Phone \_\_\_\_\_

**TO BE COMPLETED BY PARENT**

Per my signature below, Springdale Preparatory School has my permission to give \_\_\_\_\_ (name of child) the medication as ordered above by his/her health care provider.

Parent/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE USE ONLY:**

*School Nurse Signature:* \_\_\_\_\_

*Date Checked In:* \_\_\_\_\_