Circle of Life Academy

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION ADMINISTRATION FORM

STUDENT NAME_____ GRADE_____ SCHOOL YEAR _____

NON-PRESCRIPTION MEDICATION:
Parents of students requesting non-prescription (over the counter) medication to be given to their child during school hours by school staff are required to provide the school with the following information: 1. A signed parent consent and 2. Medication must be supplied in the original packaging.

Please Note** If these meds are not picked up at the end of the school year we will destroy them. _____ *(Parent Initials)* *Expiration Date of medication*_____

Medication	Dose	Time/Frequency	Route	Reason for Medication or Medical Condition

Start date: _____ Stop date: _____
(**All authorizations expire at the end of the school year or following the summer school session.)**

Parent/Guardian Authorization

I request that the above non-prescription medication be given during school hours as needed for the reasons stated above. I also request the medication be given on field trips, as needed.
I will notify the school of any change in the medication, (i.e. dosage change, medication is stopped, etc.).
If medication is non-prescription, this signature also gives permission to administer that medication.
I give permission for the medication to be given by school personnel as delegated, trained, and supervised by the school nurse.
Legally, I may refuse to sign for the medication. If I refuse to sign, we will not be able to administer the medication at school.
This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student

Permission for Release of Information

I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and medication(s) my child is taking.
I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) my child has.
I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student