# Mineral County Schools - Permission for Medication - Prescription

Healthcare Providers: complete *Healthcare Provider Section*
Parents/guardians: complete *Parent/Guardian Consent* section.
School Staff: complete *School Section.*

## Healthcare Provider Section

Name of Student:_____Date of Birth: _____

School: _____ Grade:_____

Medication:_____ Dosage :_____

If medication is for asthma rescue or anaphylaxis, please use *Asthma/Bronchodilator Medication Authorization or Anaphylaxis Action Plan* forms.

Purpose of Medication:_____

Time(s) of day medication is to be given: _____

If medication or treatment is not taken at the above time (+/- 30 minutes), how late may it still be given? _____

Possible side effects:_____

Duration: Medication/treatment to be continued until end of school year unless otherwise noted: _____

_____/ _____/ _____/_____

*Provider Signature* Date Phone PRINTED NAME OR STAMP

## Parent/Guardian Consent

- I give my permission for the above named student to take the above medication at school as ordered.
- Medication allergies: ☐ No ☐ Yes, list known allergies _____
- I understand that the medication will be given to my child by a school nurse or a school staff member.
- I will bring the medication to school myself or by another responsible adult. Students are not allowed to carry medication unless allowed to do so by law or specific school plan.
- I agree to health care provider and school nurse communication based on this medical order/permission if needed. Communication, if needed, may only include the medication or treatment itself, implementation of the treatment in school and student outcomes of the treatment.
- The medication must be brought to school in the original container, appropriately labeled by the pharmacy stating the name of the medication, the dosage, and the student's name.
- The medication cannot be past the expiration date listed on the bottle.
- I certify that my child has had at least one dose of the medication and has shown no apparent reaction to it
- Unused medication will be discarded at the end of the school year or after one month of discontinuing.

_____ _____

Date Parent or Guardian Signature

## School Section

- I verify that I received the above listed medication from the parent or a responsible adult.
- Medications to be administered as ordered. Any requests to administer dosages outside of above instructions will require a new healthcare provider order.
- Please indicate how many doses were received from the parent/guardian:_____

_____ _____

Date School Personnel Signature