O'Neill Public Schools

Parent/Guardian Authorization for all Medication Administration at School

Student Name _____**Grade** _____

Medication _____ **Dose** _____**Physician**_____

Time medication is to be given _____

If medication is given as needed, time between doses _____

How is medication taken? Circle

Oral Applied to skin Eye drops Ear drops ***Inhaled Other_____

***** NOTE: Inhalers require an action plan. Contact School Nurse.**

Reason for medication:_____

Start date: _____**End date:** _____

Special storage requirements: _____

Possible side effects: _____

_____

Medication must be brought to school by an adult and must be in the original labeled pharmacy or manufacturer's container.

I give O'Neill Public School permission to administer the above medication to my child.

_____ _____

Parent/Guardian Signature **Date**

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+++Written authorization for this medication requires a licensed health care provider's signature+++

_____ _____

Physician Signature **Date**