Pulaski Academy and Central School

For medication brought into nurse's office:

Provider and Parent Permission to Administer Medication

at School/School Sponsored Events

To Be Completed By Parent

Student Name: _____ Grade: _____

DOB: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child. This is valid for current school year.

Parent Signature: _____ Date: _____

Phone Where Parent Can Be Reached:_____

To Be Completed By Health Care Provider

Medication Order(s):

_____

_____

_____

_____

_____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

_____ _____

Name/Title of Prescriber (Please Print) **Date**

_____ _____

Prescriber's Signature **Phone**

_____

Email

Stamp

Please return to School Nurse