PINNACLE CHARTER SCHOOL

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

Child's Name________________________________ **Grade**__________ **Date of Birth**___________

- I request that my child receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the **properly labeled, original container** from the pharmacy.
- I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

____ ____
Signature (Parent or Guardian) **Please Print Name**

____
Address City State Zip

_________________________ _______________________ _____________________
Telephone No. Work Telephone No. Date

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

- **I request that my patient, as listed above, receive the following medication**:

Medication:______________________________ Diagnosis:____

Dose:___________________ Frequency:______________ Route of Administration:________________
Time:____ Duration of Treatment:_________________

Possible Side Effects and Adverse Reactions (if any): ____
____

Other Recommendations: ____
____

____ ____
Name of Licensed Prescriber & Title (please print name) **Prescriber's Signature**

____ ________________
Address City Phone No. Date

C. NOTE: This section must be signed for those students who request permission to carry their own medication on campus. The school nurse will determine a student's readiness to self carry.

SELF MEDICATION RELEASE FORM

_________________(child's name) has been instructed in the proper use of the following medication procedures:

____
Pending the school nurse's determination, we request that he/she be permitted to carry the medication on his/her person, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

____ ____
Physician's Signature Parent's Signature