

July 2011

To the Parent /Guardian of _____

Name of medications: _____

The end of the school year is quickly approaching. Please remember to pick up your child's medication in the Health Office before the last day of school on July 21. We cannot store any medication over the summer break. The school is also not able to allow your child to bring the medication home.

New medication forms are required each school year. For your convenience in preparing for next year, a medication form is enclosed. Please have it completed by your child's healthcare provider if your child will be taking medicine in school next year. It also requires a parent /guardian signature.

Any medication left at school after July 21 will be properly disposed of.

Thank you in advance for your cooperation.

Mrs. Katz
School Nurse

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: _____

Treatment: _____

Possible Side Effects and Adverse Reactions (if any):

Other Recommendations:

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

Address _____ City _____
Date _____

Phone No. _____

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 _____