	Horse Creek Academy **Permission for** **Medication**	For school use only: ☐ Routine ☐ PRN (As needed) Start Date: ___________

____ Date of Birth

Child's Name

_________________ Grade/Teacher

Allergies:

Medication: (ex. Ritalin)		Dosage: (ex. 1 tab.)
Purpose of Medication:	Strength: (ex. 10mg)	Route: (ex. by mouth)
For prescription meds. only: Prescribing Health Care Provider's signature(or provide copy of signed prescription) _________________________________ Child's Health Care Provider's Name and Telephone Number (please print):	Time of day medication to be given at school: Anticipated number of days medication needs to be given at school: ☐ until end of current school year ☐ ____ weeks ☐ ____ days Is this medication a controlled substance? ☐ No ☐ Yes Note any special storage requirements: ☐ Refrigerate ☐ Other: ___________________________	
Possible Side Effects:		

Section below to be completed by child's parent or guardian:

I give permission for my child, ____, to take the above medication at school as prescribed. I give permission for the school principal or the school nurse to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her employees to share information about this medication and my child's health with the school nurse or the school principal. I understand that the school, school district, or school personnel will not be liable for any adverse drug reaction as a result of administering medication to my child when given according to prescribed methods.

____ _________________

Signature of Parent / Guardian Date

____ _________________

Print or Type Name of Parent / Guardian Day Phone Number