GreatHearts®
CLASSICAL EDUCATION. REVOLUTIONARY SCHOOLS.™

REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION AT SCHOOL

Student Name:	Date of Birth:
Grade/Section:	Teacher (lower school only):

NAME OF MEDICATION:		Expiration Date:	
DOSAGE:		TIMES TO BE GIVEN (SCHOOL HOURS)	
DURATION:	☐ Entire School Year *(until directed otherwise)* ☐ Other duration:		
REASON FOR MEDICATION:			
QUANTITY GIVEN TO SCHOOL:		CONTROLLED SUBSTANCE?	
Any additional information?			

PLEASE NOTE:

1. Written authorization is required to ***discontinue*** prescription medication.
2. Medication will be dispensed during school hours only.
3. CONTROLLED SUBSTANCES MAY ONLY BE RECEIVED BY A SCHOOL NURSE OR DESIGNATED PERSONNEL.

CONSENT

Parent Consent: I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose the above information to those within the school district who have a need to know for legitimate educational purposes.

I understand that medications are to be dispensed during school hours only.

PARENT/GUARDIAN SIGNATURE:		DATE:	
PARENT CELL PHONE *(or best daytime number):*			