GreatHearts®
CLASSICAL EDUCATION. REVOLUTIONARY SCHOOLS.™

# 2024-2025

## REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION AT SCHOOL

| | |
|---|---|
| Student Name: | Date of Birth: |
| Grade/Section: | Teacher: |

| | | | |
|---|---|---|---|
| NAME OF MEDICATION: | | Expiration Date: | |
| DOSAGE: | | FREQUENCY/ADMINISTRATION TIMES | |
| DURATION: | Entire School Year *(until directed otherwise)* Other duration: | | |
| REASON FOR MEDICATION: | | | |
| **QUANTITY GIVEN TO SCHOOL** | | | |
| Current weight: | | | |
| Medication Allergies: | | | |
| Any additional information? | | | |

PLEASE NOTE:

1. Written authorization is required to ***discontinue*** prescription medication.
2. Medication will be dispensed during clinic 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 clinic hours only.

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

NOTE: PLEASE INDICATE BELOW YOUR PREFERENCE FOR DISPOSITON OF ANY UNUSED PORTION OF YOUR CHILD'S MEDICATION.

- ❑ Parent will pick up unused medication.
- ❑ Unused medication will be properly disposed of by school nurse.

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**CLINIC USE ONLY**

| Date received: | Quantity Received: | Total amount: | RN Signature: | Parent/ Guardian Signature: |
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Sent Home Date:_____ Quantity Sent Home: _____

Sent Home With: _____

Nurse Signature: _____

Controlled substances/Epi pens and Seizure medications need to be dropped off and picked up by a parent/legal guardian and my not be send home with the student.