Please have a physician (or physician assistant or advanced practice registered nurse) complete this permission form if your child needs prescription or over-the-counter medication to be administered during school hours. No medication will be given in school until proper documentation is received, and the medication is in the original bottle.

Student Name: _____ Birth Date: _____

Year Group: _____ Teacher/Form Tutor: _____

Parents, do not complete this section. This section should be completed by your child's physician (or physician assistant or advanced practice registered nurse).

Medication to be given in school: _____

Diagnosis/Purpose: _____

Dose/Route: _____ Frequency: _____

Time to be administered: _____ Date to be discontinued: _____

Expected side effects: _____

Other medications student is taking: _____

Is the student authorized to self-administer medication? ☐ Yes ☐ No

Prescriber Signature: _____ Date: _____

Prescriber Telephone: _____

Please note that in the Primary School, emergency medications, such as EpiPens and inhalers, are stored with classroom teachers and travel with the class as they go on break, to lunch, and to specialty classrooms. It is best to provide two EpiPens or inhalers so that one may be kept with the classroom teacher and a second in the nurse's office. Secondary students carry these emergency medications with them throughout the school day.

Parental Authorization

I acknowledge that I am primarily responsible for administering medication to my child. In the event that I am unable to do so, or in the event of an emergency, I hereby authorize [redacted] and its employees to administer lawfully prescribed medication to my child. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against [redacted] and its employees arising out of the administration of said medication.

Parent Signature: _____ Date: _____