AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION AT SCHOOL (Med Form 1)

Bob Jones Academy

Must be signed by parent.

Please print

School year _____

Student's name _____ Date of birth _____

Parent _____

Home phone _____ Work phone _____ Cell phone _____

Name of medication _____

Reason for dispensing medication at school (please be specific) _____

_____

Amount of medication to be given _____

Date to ***START*** medication _____ Date to ***STOP*** medication _____

Time of day medication is to be given _____

Expiration date of medication _____

Possible side effects _____

Student's primary physician _____ Physician's phone _____

Parent, please read carefully:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. ***I will notify the school if the medication is discontinued or the dosage has been changed.*** Permission is granted to the principal and/or school nurse to share this information with other school personnel who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse permission to contact the physician's office named above to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

Parent's signature _____ Date _____

Please note:

- A separate permission form is required for each medication to be given.
- Parents are responsible for noting the expiration date of all medication. Expired medication will not be given at school.
- Any medication not picked up by 2 weeks after the last day of school will be destroyed according to school guidelines.
- Any over-the-counter medication given every day for 10 consecutive days must have physician's authorization.

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