

Student Name \_\_\_\_\_ FORM A

**Rochester Community Schools**  
**Permission for Prescribed Medication at School**

School \_\_\_\_\_ Teacher \_\_\_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Physician or Licensed Prescriber Authorization**

*Only one medication order per form*

**Name of Medication** \_\_\_\_\_ **Dose** \_\_\_\_\_ **Route** \_\_\_\_\_

**Reason** for medication \_\_\_\_\_

**Routine time(s)** to give during the school day \_\_\_\_\_ As needed (PRN) every \_\_\_\_\_

**YES**  **NO** Episodic/Emergency use only

**YES**  **NO** It is my professional opinion that this student is responsible and knowledgeable about the proper use of this medication and should be allowed to self-carry at school.

**YES**  **NO** Start Date upon delivery of the medication and this permission to school. (Received \_\_\_\_\_)

**YES**  **NO** Stop Date at the end of the current school year.

**Other Start Date** \_\_\_\_\_ **Other End Date** \_\_\_\_\_

Administration instructions \_\_\_\_\_

Storage instructions \_\_\_\_\_

Possible side effects/adverse reactions \_\_\_\_\_

Physician/Licensed prescriber (**print name**) \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Fax number** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parental Permission**

I request that school staff give my child the above medication as ordered. I give permission for the prescriber to be contacted by school staff about this order if clarification is needed.

**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

*Signature*

**Phone Number** \_\_\_\_\_ Alternate number \_\_\_\_\_

*Medication should be in the original labeled container. It is the parent/guardian responsibility to: replace expired medication; provide refills when needed; transport the medication to & from the school office; and pick it up at the end of the school year. The school does not store medicine over the summer.*