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.