GreatHearts®
CLASSICAL EDUCATION. REVOLUTIONARY SCHOOLS.™

REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION AT SCHOOL

Student Name:	Date of Birth:
Grade/Section:	Teacher (lower school only):

NAME OF MEDICATION:		Expiration Date:	
DOSAGE:		TIMES TO BE GIVEN (SCHOOL HOURS)	
DURATION:	☐ Entire School Year *(until directed otherwise)* ☐ Other duration:		
REASON FOR MEDICATION:			
QUANTITY GIVEN TO SCHOOL:		CONTROLLED SUBSTANCE?	
Any additional information?			

PLEASE NOTE:

1. Written authorization is required to ***discontinue*** prescription medication.
2. Prescription inhalant medication may be carried by the student ONLY if directed in writing by the Physician and Parent. (Complete form for Asthma Inhalers at School.)
3. Medication will be dispensed during school hour only.
4. CONTROLLED SUBSTANCES MAY ONLY BE RECEIVED BY A SCHOOL NURSE OR DESIGNATED PERSONELL.

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 school hours only.

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

NOTE: PLEASE INDICATE BELOW YOUR PREFERENCE FOR DISPOSITON OF ANY UN-USED PORTION OF YOU CHILD'S MEDICATION.

Parent will pick up medication (PARENT MUST PICK UP CONTROLLED SUBSTANCE) Send medication home with student

OFFICE USE

Date Medication Received: ________________ Quantity Received: __________ Initial: ______________________
Refill Date: _____________ Quantity: ________ Received by: _______________ From: ___________
Refill Date: _____________ Quantity: ________ Received by: _______________ From: ___________
Refill Date: _____________ Quantity: ________ Received by: _______________ From: ___________
Refill Date: _____________ Quantity: ________ Received by: _______________ From: ___________