NORTH SHORE CENTRAL SCHOOL DISTRICT

Provider and Parent Permission to Administer Medication At School/School Sponsored Events

Part A: To Be Completed by Parent/Guardian

Student Name: ____ DOB: __________________

Grade: ____________ Teacher/HR: ____________________________ School: _________________

I request/authorize the school nurse administer the medication on this plan; or after the school nurse determines my child can take their own medications, trained staff may assist my child to take their own medications, including on field trips. I will provide the medication in the original, pharmacy or over-the-counter container and ensure the expiration date lasts throughout the school year. I will replace expired medication as required and on time. Medication/refills must be brought to school by an adult. This plan may be shared with school staff caring for my child as necessary on a need-to-know basis.

Parent/Guardian (print): _____________________________________ Date: __________________

Parent/Guardian Signature: __________________________________ Phone: _________________

Part B: To Be Completed by a Licensed Healthcare Provider

Valid 20 ____ - 20 ____ School Year

Name of Student: ____ DOB: ________________

DIAGNOSIS/ LIST ALL ALLERGENS/ INDICATION	MEDICATION	DOSAGE	ROUTE	FREQUENCY/ TIME

Duration of Treatment: _____________________________ Possible Side Effects:________________________

Name/Title of Provider (Print): _____________________________________ Date: ___________________

Provider's Signature:____ Phone: ________________

Office Stamp **REQUIRED**:

(4/23)