PINNACLE CLASSICAL ACADEMY

2015-2016
Request for Medication (Prescription and/or Over-the-Counter) To Be Given
<u>During School Hours Or On Any School Sponsored Field Trips</u>

_____	_____	_____	_____
Student	Date of Birth	Grade	Allergies

MEDICATION _____ **DOSAGE** _____
(NO injections will be given except in case of extreme emergencies such as allergy to wasp or bee sting)

TIME of medication administration AM _____ **PM** _____

Start Date: _____ **End Date:** _____

School to administer medication (physician's initials _____)

If prescription is for EPI PEN, INHALER, or INSULIN student may self-carry and self-administer the medicine. I have provided education and he/she is knowledgeable and has demonstrated the necessary skill level for this medication (physician's initials _____).
Special instructions or possible adverse reactions: (Please list – type or print clearly)

_____

_____

_____	_____	_____
Physician Signature	Date	Telephone Number

<u>PARENT'S PERMISSION</u>
I hereby give my permission for my child (named above) to receive medication during school hours. A licensed physician has prescribed the medication, and I hereby release the School Board, their agents, and employees from all liability that may result from my child taking the prescribed medication. I will furnish this medication in a container properly labeled by a pharmacist with identifying information (i.e. name of the child, medication dispensed, dosage prescribed, and the time it is to be given.)

_____	_____	_____
Parent or Guardian Signature	Date	Telephone number

This form must be completed if your child will need medication on a school sponsored overnight or extended field trip.

The Form and Medication must be provided to the school nurse and designee one week prior to the field trip.

Reviewed by: _____ Date _____
Nurse or Designee