ATLANTIS
CHARTER SCHOOL

Parent/Guardian Authorization
For Prescription Medication Administration

Student's name: _____

Parent/Guardian printed name: _____

Telephone number – Home: _____ Cell Phone Number: _____

Telephone number – Work: _____

Telephone number – Emergency: _____

Other person(s) to be notified in case of medication emergency:

Name: _____ Telephone Number: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality): _____

My son/daughter has the following food or drug allergies: _____

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication prescribed by:

_____ to _____
Licensed Prescriber Student's Name

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

_____ Yes _____ No

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is I not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian signature: _____

Relationship to student: _____

Address: _____

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Medication Order Form

(to be completed by a licensed prescriber)

Name of Student_____ Date of Birth _____

Address_____ Grade _____
(street) (city/town)

Name of Licensed Prescriber_____

Title_____

Business Phone_____ Emergency Phone_____

Medication_____

Route of administration_____

Dosage_____

Frequency_____ Time(s) of administration_____
(Please note: Whenever possible, medication should be scheduled at times other than school hours).

Specific directions or information for administration:_____

Date of Order_____ Discontinuation Date_____

Diagnosis*_____

Any other medical
condition(s)*_____

Optional Information
1. Special side effects, contraindications, or possible adverse reactions to be observed:_____
2. Other medication being taken by the student:_____
_____
3. The date of the next scheduled visit or when advised to return to prescriber: _____
4. Consent for self administration (provided the school nurse determines it is safe and appropriate).
Yes_____ No_____

_____
Signature of Licensed Prescriber
* if not in violation of confidentiality.