Pine Springs
PREPARATORY ACADEMY
A Challenge Foundation Academy

# SHORT-TERM PRESCRIPTION MEDICATION PARENTAL PERMISSION FORM

- FOR PRESCRIPTION MEDICATION ONLY
- MEDICATION WILL NOT BE SENT BACK & FORTH WITH STUDENT EACH DAY
- WILL BE ADMINISTERED FOR 2 WEEKS OR LESS
- MUST BE IN A PHARMACY CONTAINER WITH A PHARMACY LABEL TO INCLUDE: Student Name, Medication Name, Dose, Route, Time of Administration, Date Filled, Expiration Date of Medication
- FIRST DOSE OF ANY NEW MEDICATION MUST BE ADMINISTERED AT HOME

Student Name: _____ DOB: _____ Grade/Teacher: _____

*Medication: _____ *Dose: _____ *Route: _____

**(*MUST match prescription label)**

Time to be administered: _____

Side effects/contraindications: _____

Reason for medication: _____

Start Date: _____ First dose administered at home by parent/guardian? Y / N

End Date: _____ Expiration Date: _____

_____ _____ _____

Parent/Guardian Signature Daytime Phone Date

_____ _____

School Nurse Signature Date