	Permission for School Administration of Non-Prescription Medication DAYSPRING ACADEMY	For school use only: ☐ Routine ☐ PRN (As needed) Start Date: _____

Medications should be administered by a parent or guardian before or after school hours, when possible. Over the counter medications may only be given with the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that Dayspring Academy may reject requests for certain medications to be given at school.

_____ _____
Child's Name Date of Birth

_____ _____
Name of School Grade

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day medication to be given at school: If possible, please specify preferred time. Lunch times vary (10:30a – 1p).	Note any special storage requirements: ☐ None ☐ Refrigerate ☐ Other (please specify):
Anticipated number of days medication will be given at school: ☐ until end of current school year ☐ ____ weeks ☐ ____ days	Is child allergic to any food, medicines, or other items? ☐ No ☐ Yes (List allergies.) Is this medication a controlled substance? ☐ No ☐ Yes
Does your child take any other medications at home or at school? __No __Yes (if yes, what are the medications?)	

Child's Health Care Provider's Name and Address (please print):	
	Office Phone Number
	Office Fax Number

Section below to be completed by child's parent or guardian:

I give permission for the medication above to be given to my child during the school day. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that the school may require that I agree to Dayspring Academy's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if my child's medications change in any way.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Print or Type Name of Parent / Guardian Day Phone Number

Reviewed June 2010