



**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: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other (please specify):	
Anticipated number of days medication will be given at school: <input type="checkbox"/> until end of current school year <input type="checkbox"/> ___ weeks <input type="checkbox"/> ___ days	Is child allergic to any food, medicines, or other items? <input type="checkbox"/> No <input type="checkbox"/> Yes (List allergies.)	
	Is this medication a controlled substance? <input type="checkbox"/> No <input type="checkbox"/> 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 _____