



North Central Charter Essential School Medication Order/Permission Form

Student Name _____ Grade _____

Address _____ Date of Birth _____

TO BE COMPLETED BY A PARENT/GUARDIAN

My child is currently receiving the following medications (complete if not in violation of confidentiality)

My child has the following food or drug allergies _____

I give my consent to the school nurse or other school personnel designated by the school nurse to administer the medication(s) prescribed by _____ to _____.

Licensed Prescriber

Student Name

I give permission for my child to receive the medication as directed below and I will notify the nurse of any modifications.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____ Home Phone _____

Cell Phone _____ Work Phone _____ Emergency Phone _____

- Note:**
- 1. Whenever possible, please administer medications at home.**
 - 2. Any medications, not picked up by an adult within one week of the close of school, will be destroyed.**

TO BE COMPLETED BY A PHYSICIAN/DENTIST:

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Route/Admin.</u>	<u>Duration / Discontinue Date</u>	<u>Illness</u>
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					

Indicate any restrictions, special instructions, contraindications, or side effects on any of the above medications.

The student may self-administer the above medication (inhaler, Epi-Pen, etc.) at the discretion of the school nurse.

Yes ___ No ___

Diagnosis (if not in violation of confidentiality)

Physician/Dentist Signature _____ Date _____

Physician/Dentist Printed Name _____

Phone No. _____

Emergency Contact No. _____