☐ Office File
☐ Student Medical File

Permission for Prescription Medication (2019/2020)

Student Last Name, First Name _____ **Birth Date** _____ **Grade** _____

City Academy does not allow students to have prescription medications in their possession. If your child requires a prescription medication while at school, we require you list, describe it below and bring it to the main office. All medications are stored in the main office and will be dispensed as prescribed by the appropriate personnel.

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL
(Please clearly print legible instructions)

(1) Name of medication	**Dosage**	**Method of Administration**	**Times to be Taken**

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ to _____ (dates) (not to exceed current school year). There exists a valid health reason which may make administration of the medication advisable during school hours.

_____ _____
Signature of Licensed Health Professional (LHP) Date of Signature

_____ _____
Print Name of Licensed Health Professional (LHP) Telephone Number

(2) Name of medication	**Dosage**	**Method of Administration**	**Times to be Taken**

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ to _____ (dates) (not to exceed current school year). There exists a valid health reason which may make administration of the medication advisable during school hours.

_____ _____
Signature of Licensed Health Professional (LHP) Date of Signature

_____ _____
Print Name of Licensed Health Professional (LHP) Telephone Number

(over)

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Permission for Prescription Medication (2019/2020) ***(cont.)***

Student Last Name, First Name | **Birth Date** | **Grade**

(3) Name of medication	**Dosage**	**Method of Administration**	**Times to be Taken**

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ (date) to _____ (date) (not to exceed current school year). There exists a valid health reason which may make administration of the medication advisable during school hours.

Signature of Licensed Health Professional (LHP) | Date of Signature

Print Name of Licensed Health Professional (LHP) | Telephone Number

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Consent for Administration of Medicine and Medical Information

We request the medication(s) be given as ordered by the licensed health professional. We hereby release the school from responsibility and liability and agree to hold City Academy harmless in the event of accident or injury associated with any medications that we allow school personnel to give our child. We understand oral medications may be administered by non-licensed school personnel who have been trained. We give school personnel permission to communicate with the medical office and 911 staff, if they are called, about this medication. **All medication supplied will be brought to school in its original container with instructions as noted above by the licensed health professional.**

By signing below we intend to waive any rights to sue or otherwise make any claim against City Academy or its officers, directors, employees, agents and volunteers for any reason including negligence of any of them. We understand the effect of this release and permission form and accept all of these risks. If any information changes, we agree to update this form by contacting in writing (via email, regular mail or fax) the Main Office of the school.

Signature of both Parents/Custodial Parent/Guardian | Date of Signature

Telephone Numbers:	**HOME**	**WORK**	**CELL**
Mother/Guardian			
Father			