Medical *Information* and Consent to Dispense Medications – SY 2019/2020

Student's Name (Please Print):_____**Birthdate:**_____

Known Allergies:_____

List All Medical Concerns:_____

Parent Provided *Over-the-Counter Medications* – These are to be furnished by the parent, in the original container with the student's name and dosage instructions provided. Medications to be administered more than 10 days must have a physician's order. Medications not picked-up within 10 days will be disposed of in accordance to federal guidelines. Expired medication or medications without proper dosage instructions **will not** be administered to student.

Date	Name of Medication	Route (by mouth, etc.)	Dosage	Time	Indication for treatment	Possible Side Effects	Parent/Guardian's Initials

Parent Provided *Prescription Medications* – **All** medications must be furnished by the parent in the original container with affixed prescription label. No more than a 30 days' supply of medication should be brought to the health office. All controlled substances should be brought into the health office by a Parent/guardian.

Date	Name of Medication	Route (by mouth, etc.)	Dosage	Time	Indication for treatment	Possible Side Effects	Parent/Guardian's Initials

Special Requirements (example: take with food):_____

I hereby authorize any hospital/doctor/EMS personnel to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

By signing below, I give my consent for the school nurse or other designated school staff to dispense the medication(s) noted above to my child. I acknowledge that Great Hearts personnel are not responsible for any ill effects which may occur. **Note: The very first dose of this medication for current condition/illness may not be given at school.**

Signature of Parent/Guardian: _____ Date: _____