

Brentwood School District  
90 Yorkshire Lane  
Brentwood, MO 63144

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

In addition to prescription medicines, district policy allows over the counter medicines to be given for up to five days based on a parent's signature. Extended use of over the counter medicines will require a physician's order. District practice also requires that medicines be given at non-school times if at all possible. Medicine must be in an original container and accompanied by this completed form.

\_\_\_\_\_  
Name of school

\_\_\_\_\_  
Date form received by school

**Student Information**

Name \_\_\_\_\_ Age \_\_\_\_ Date of birth \_\_\_\_\_

Homeroom/Classroom \_\_\_\_\_ Grade \_\_\_\_\_

**Medication Information**

\_\_\_\_ Prescription Medicine \_\_\_\_\_ Over the counter medicine provided by parent/guardian

Has the student been given the first dose of this medicine \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of medicine \_\_\_\_\_ Reason for medicine \_\_\_\_\_

Times to be given \_\_\_\_\_ Daily \_\_\_\_\_ As needed \_\_\_\_\_

Dates to be given From \_\_\_\_\_ To \_\_\_\_\_

Form of medicine or treatment \_\_\_\_\_ Tablet/capsule \_\_\_\_\_ Liquid \_\_\_\_\_ Inhaler \_\_\_\_\_ Injection

\_\_\_\_\_ Nebulizer \_\_\_\_\_ Other \_\_\_\_\_

Describe dose to be given at school \_\_\_\_\_

If "as needed" indicate maximum dose per day \_\_\_\_\_

Any restrictions and/or important side effects \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe \_\_\_\_\_

Special storage requirement \_\_\_\_\_ None \_\_\_\_\_ Refrigerate \_\_\_\_\_ Other \_\_\_\_\_

**AUTHORIZATION/PERMISSION**

I give permission for \_\_\_\_\_ (student's name) to receive the above medication at school.

I also give district employees permission to contact the student's physician directly to provide information on the student's condition. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medicine and for informing the school immediately if any information provided on this form changes or if administration of the medication should cease. I release school personnel from liability should reactions result from giving the medicine. In case of an emergency needing further attention, transport to the facility indicated.

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell phone/pager \_\_\_\_\_ Emergency phone \_\_\_\_\_

(Physician and hospital information on back of form)

In the event of an emergency take my student to \_\_\_\_\_  
Hospital

**Physician Information**

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

Please administer \_\_\_\_\_ to \_\_\_\_\_  
Name of medication student's name

at \_\_\_\_\_ for \_\_\_\_\_  
Time/daily/as needed Reason for medicine

Medicine to be given from \_\_\_\_\_ to \_\_\_\_\_

Possible side effects \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

*Notice*

*Schools in this district are equipped with epinephrine pre-measured auto-injection devices that can be administered in the event of severe allergic reactions that cause anaphylaxis. Epinephrine will be administered only in accordance with written protocols provided by the authorized prescriber. The school principal/office will maintain a list of personnel trained in the proper administration of this drug.*