PACE Academy
RX Medication Permission Form
2023-2024 School Year

For School Use Only:
☐ Routine Use
☐ PRN (as needed)
Start Date: _____

Medications should be administered by a legal parent or guardian before or after school hours, when possible. Initial doses of a medication that the child has never taken before should not be given at school. Any medication to be administered during the school day must be provided by the student's guardian in the original labeled container along with this form, complete with the child's healthcare provider's signature. The medication must be in the original labeled container. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name and directions for proper administration. Herbal/alternative medicinal products will not be administered in the school setting.

By signing this form, the parent/guardian and healthcare provider acknowledge that information from this form may be included in the student's Individual Health Care Plan (IHP), if applicable. If all of the treatment plan or medical orders will be followed by the school as written and the IHP is consistent with the treatment plan or medical orders, the signature of the Health Care Provider and the student's parent/guardian on the IHP will not be required. The IHP will be shared with other school staff who have a legitimate need for knowledge of the information.

_____ _____ _____
Child's name | Date of Birth | Grade

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day medication is to be given at school: If possible, please specify preferred time. Lunch times vary (10:30-1:00).	Note any special storage requirements: ☐ None ☐ Refrigerate ☐ Other (please specify):
Anticipated number of days medication will be given at school: ☐ Until the end of the current school year ☐ _____ weeks ☐ _____ days	Is the child allergic to any food, medicines, or other items? ☐ No ☐ Yes (List allergies)
Is this medication a controlled substance? ☐ No ☐ Yes	Possible side effects:

PLEASE LIST ICD-10 DIAGNOSIS CODE FOR THIS STUDENT'S CONDITION: ICD-10 CODE_____

_____ _____
Healthcare Provider's Signature | Date

Stamp, print, or type Healthcare Provider's name and address:	Healthcare Provider's Office Phone Number:	Healthcare Provider's Office Fax Number:

Section below to be completed by student's parent or guardian:

I give permission for my child to be given the above medication as prescribed. I give permission for the school nurse or administrator to contact the healthcare provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the healthcare 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 also give permission for this "permission for school administration of medication" form to apply if I transfer my child to another school in the same school district during the same school year. I understand that the school may require that I agree to the school's rules about medications before this medicine will be given at school. I further understand that any after school program not operated by the school or school district (ex. Boys and Girls Club) will not have access to the medication described above and that it is my responsibility to provide the operator of the after school club program with any necessary medication and training including emergency medication for my child. I will not hold the school, school district, or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. If an IHP is developed that encompasses these medical orders, I understand this plan of care is for my child while he/she is at school or is attending school-sponsored functions. I agree to notify the school of changes in my child's health condition, medication and/or contact information. I give permission for a trained Unlicensed Assistive Personnel (UAP) to assist my child with medication in the absence of the school nurse.

_____ _____
Signature of Guardian | Date

_____ _____
Print or Type Name of Guardian | Daytime Phone Number