

SIERRA GRANDE SCHOOL DISTRICT R-30

Permission for Medication Administration at School and Child Care

The parent/guardian of	Child's Name	that school/child care staff give the
following medication	Crilia's Name	at
N	lame of Medicine & Dosage	Time(s)
to my child, according to the Heal	th Care Provider's signed instructions	on the lower part of this form
medicine is to be given, dosag		child's name, name of medicine, time oe stopped, and licensed Health Care luded on the label.
	st be labeled with child's name. Dosa cine must be packaged in original conf	age must match the signed Health Care tainer.
prescriptive authority. The pare notification by staff. All medication regulatory recommendations for stage of the stage o	ent agrees to pick up expired or upon(s) left at the school will be discard safe medication disposal.	y a licensed Health Care Provider with nused medication within one week of ded according to the most current state the Care Provider to share information delegated to administer medication.
Parent/Legal Guardian's Name	Parent/Legal Guardian Signa	ature Date
Work Phone	Alte	rnate Phone
THORIC STREET		
*********	**********	**************************************
**********	************	************
**************************************	Health Care Provider Authoriz	**************************************
**************************************	************	************
**************************************	************	**************************************
	**************************************	ation Birthdate:
Medication:	Health Care Provider Authoriz Dosage:	ation Birthdate: Route:
Medication: To be given at the following times:	Health Care Provider Authoriz Dosage:	ation Birthdate: Route:
Medication: To be given at the following times: Special Instructions:	Health Care Provider Authoriz Dosage:	ation Birthdate: Route:
Medication: To be given at the following times: Special Instructions: Purpose of Medication:	Health Care Provider Authoriz Dosage:	ation Birthdate: Route:
Medication: To be given at the following times: Special Instructions: Purpose of Medication:	Health Care Provider Authoriz Dosage: Start Date:	ation Birthdate: Route:
Medication: To be given at the following times: Special Instructions: Purpose of Medication: Side Effects to be reported:	Health Care Provider Authoriz Dosage: Start Date:	ation Birthdate Route End Date

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