PARENTAL PERMISSION/ HEALTH CARE PRACTITIONER ORDER
TO ADMINISTER MEDICATION

PRESCRIPTION MEDICATION:
Health Care Practitioner /Medication Instructions /Allergy/Asthma

NON-PRESCRIPTION MEDICATION:
Student Information/ Medication Instruction/ Parent Consent

Student Information:

Student's Name_____ Grade_____Birthdate_____
Address_____Phone_____

1. Health Care Practitioner Order/Medication Instructions: Health care practitioner complete for **each prescription medication** to be administered at school:

- School Year or Effective Date_____ (Start – End Date)

Medication_____ Dosage_____Time_____Route_____
Reason for Medication_____
Contact should the following side effects occur: _____
Date_____**Health Care Practitioner's Name**_____
Phone_____**Health Care Practitioner's Signature**_____

- School Year or Effective Date_____ (Start – End Date)

Medication_____ Dosage_____Time_____Route_____
Reason for Medication_____
Contact should the following side effects occur: _____
Date_____ **Health Care Practitioner's Name**_____
Phone_____**Health Care Practitioner's Signature**_____

ASTHMA inhalers: Medication_____Dosage_____Time_____Route_____
Student may carry inhaler in school. Yes ____ No_____
Health Care Practitioner's Name_____ Phone_____

Health Care Practitioner's Signature_____Date_____

ALLERGY Epi-pen: Medication_____Dosage_____Time_____Route_____
Student may carry Epi-pen in school. Yes ____ No_____
ALLERGY_____

Health Care Practitioner's Name_____Phone_____

Health Care Practitioner's Signature_____Date_____

2. Medication (Non-Prescription*) Instructions:

Parent/Guardian complete for **each nonprescription medication to be administered** at school:

- School Year or Effective Date_____ (Start – End Date)

Medication_____ Dosage(per label)_____ Time_____ Route_____
Reason for Medication_____

- School Year or Effective Date_____ (Start – End Date)

Medication_____ Dosage(per label)____Time_____Route_____
Reason for Medication_____

_____ _____ _____
Signature of Parent/Guardian Phone Number Date
*Non-Prescription Medication will be administered per label dosage.

3. Parent/Guardian Consent: Complete for **each medication** at school.

I request that this medication be administered at school by the designated employee.

I will supply the medication in its original, properly labeled pharmacy container.

I will count the medication and will notify the school of the amount being sent.

I will notify the school **in writing** of any medication changes, and will obtain a new health care practitioner's order *(applicable to prescription medication).*

I authorize school personnel to contact my child's health care practitioner if needed. *(applicable to prescription medication)*

This consent is in effect for the school year unless otherwise indicated.

Date_____Parent/Guardian Signature_____

Phone (home)_____Phone (work)_____

The completed form may be returned by fax to the school offices as follows:

Altoona Elementary & 4K:	Altoona Intermediate/Middle School:	Altoona High School:
715-839-6166	715-839-6099	715-839-6028

Approved: 5/18/09
Amended: 2/28/22