** If your child takes long term medication, have this form filled out by a physician and bring to the DCA nurse's office prior to the first day of school.*

PERMISSION TO RECEIVE LONG TERM MEDICATION FORM

*****Must Be Completed By A Licensed Physician, or others authorized by Chapter 94C*****

Name of Student _____ Date of Birth _____

Name of Medication _____

Specific time(s) and dose(s) to be given at school:

Dosage _____ Times to be Administered _____

Route of Administration _____

Duration of Use/Frequency

_____

Specific Directions or Information for Administration of Medication _____

_____

Date of Order _____ Discontinue Date _____

Diagnosis/Purpose of Medication* _____

Any Other Medical Conditions* _____

Other Medications Taken by the Student _____

Possible side effects _____

Is this condition contagious? _____ Yes _____ No

Are there any restrictions? _____ Yes _____ No

If yes, please list restrictions _____

_____

Is student permitted to carry and self-medicate _____ Yes _____ No

If yes, what and how long

_____

_____

Name of Physician _____ Phone _____

Signature of Physician _____ Date _____

Permission to fax: _____ ***Parent signature/date***

PARENT/GUARDIAN CONSENT FOR All PRESCRIBED MEDICATION ADMINISTRATION

To Be Completed By Parent

General Information

Name of Student _____ Date of Birth _____

Grade Level Entering _____ Student's Gender _____

School Attending _____

Name of Parent(s)/Guardian(s) (Please print) _____

_____

Address _____

Home/Cell Phone _____ Work Phone _____

Best Emergency Contact Phone Number _____

Other Persons to be Notified in Case of Emergency if Parent/Guardian is Unavailable:

Name _____ Phone _____

Relationship _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

(Please list all medications the child is receiving, including those given during the school day)

1._____ 2._____ 3._____ 4._____

My son/daughter is known to have the following allergies: _____

_____

CONSENT SIGNATURE FORM

1. I, _____, give permission to the school nurse, or other school
(Parent/Guardian)

personnel designated by the school nurse, to administer the following medication(s):

_____
(Name of Medications)

as prescribe by _____ to my child _____
(Name of Prescriber) (Name of Student)

2. I give permission for my son/daughter to self-administer medication if the licensed prescriber has given authorization and the school nurse determines it is safe and appropriate. Yes _____ No _____

3. I give permission to the school nurse to share, with the appropriate school personnel, information relative to the prescribed medication administration as she/he determines necessary for my son's/daughter's health and safety. Yes _____ No _____

Any restrictions on information release _____

_____/_____ I/We understand that I/We may retrieve the medicine from the school at any time and
(parent initials) that the medicine will be destroyed if it is not picked up within one week following the termination of the order, one week beyond the end of the school year, one week beyond the student's enrollment at DCA, or if the medication has expired.

Father's/Guardian's Name: _____ Date: _____
(Print Name)

Father's/Guardian's Name: _____ Date: _____
(Signature)

Mother's/Gaurdian's Name: _____ Date: _____
(Print Name)

Mother's/Gaurdian's Name: _____ Date: _____
(Signature)

This Form Must Be Updated Annually