Heritage Academy

Heritage Academy – Maricopa Campus

CONSENT FOR GIVING PRESCRIPTION AND NON-PRESCRIPTION MEDICATION AT SCHOOL

Please check here if non-prescription ☐

Scholar name: _____ Birthdate_____

For prescription medication, your physician must complete the information required below. Medication must be delivered to school in the original container with the label intact, and is to be given in the following manner:

Name and strength of medication: _____

Amount to be given: _____

Time of administration at school: _____ a.m. _____ p.m.

Medication to be administered (circle one): Topical Oral

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

Physician's Name: _____ Phone No: _____

(Please print)

_____ _____

Physician's Signature **Date**

I hereby request and give my consent for the person designated by the principal to administer the medication indicated above. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of prescription medication. I hereby give permission for the exchange of information regarding my child's medication.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Parent/Guardian Home Phone Number Parent/Guardian Work Phone Number

** If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed.