Permission for Prescription Medication

For school use: □ Routine □ PRN Start Date: ____/____/_____

_____ ___/___/_____

Child's Name Date of Birth

Medication:	Dosage:
Purpose of Medication:	Route:

When possible, medications should be given at home before drop-off or after pick-up. No medication will be given at Five Rose Lane without parent's written permission. Prescription medications also require authorization from the student's Health Care Provider. All medications must be in their original container and must be properly labeled. Students are not allowed to keep medication with them. Students are not allowed to take medication home with them. An adult must pick up any unused medications. Five Rose Lane will not return unused medications to students. Medications not picked up by the last day of spring session will be destroyed.

Time of day medication to be given at school:

□ Every morning □ Lunchtime

□ Only if needed □ Other_____

Anticipated number of days medication needs to be given at school:

□ until end of current school year

□ _____ weeks □ _____ days

Possible Side Effects:

Prescription Medications Require Health Care Provider Authorization

Prescribing Health Care Provider's Signature: (Or provide copy of signed prescription)	Date:
Insert Provider's Name and Address Stamp Below:	Office Phone Number:
	Office Fax Number:

I give permission for my child, _____, to take the above medication at Five Rose Lane as prescribed. I give permission for the health care provider or his/her employees to share information about this medication and my child's health with the director of Five Rose Lane. I understand that Five Rose Lane has a written medication policy and by signing below, I agree to adhere to it.

_____ ____/____/_____

Signature of Parent/Guardian Date

_____

Permission for Non-Prescription Medication

For school use: □ Routine □ PRN Start Date: ____/____/_____

_____ ___/___/_____

Child's Name Date of Birth

When possible, medications should be given to students before or after school. Five Rose Lane, however, recognizes that it may be necessary for medications to be given at school and has developed written procedures for the safety of students. No medication will be given without written parental permission. All medications must be provided in their original container. Over the counter medications may be given within the age appropriate guidelines indicated on the container or package insert. Five Rose Lane reserves the right to reject requests for certain medications to be given at school.

Name of medication to be given:			Amount to be given:
Reason for medication:			
Time of day medication to be given at school: □ Every morning □ Lunchtime □ Only if needed □ Other _____	Anticipated length of time medication needs to be given at school: □ Until end of current school year □ _____ Weeks □ _____ Days		
Does your child take any other medications?	Yes	No	If yes, please list:
Is your child allergic to any food, medicine, or other items?	Yes	No	If yes, please list:
Health Care Provider's Name:			

I give permission for my child, _____, to take the above medication at Five Rose Lane. I give permission for the health care provider or his/her employees to share information about this medication and my child's health with the director of Five Rose Lane. I agree to notify the school of any changes in my child's health status that may influence this medication's administration. I understand that Five Rose Lane has a written medication policy and by signing below, I agree to adhere to it.

_____ ____/____/_____

Signature of Parent/Guardian Date

_____