Teacher / Grade________________

School Year:________________

PARENT/GUARDIAN MEDICATION PERMISSION FORM

(This form must be completed before a parent-prescribed, self-prescribed, or doctor-prescribed medication can be taken by a student at school.)

Dear Parent/Guardian,

Brookhaven Innovation Academy has received a request from you that ______________________________ is taking medication and will need to take it during school hours. We request that you fill out this form for your child and keep us updated on medication dosage and/or treatment changes.

We also ask for your assistance in helping us with the large amount of medication that is being taken by students during school hours. We request that if the medication can be taken at home instead of during school hours that the parent/guardian be encouraged to do so.

Medication will only be given if it is **delivered to the school in the original bottle**, marked with the student's name, dosage, the time to be administered, Health Care Provider name, pharmacy name, and date of purchase. Parents must deliver medication to the school. For safety reasons, do not send medications in student book bags. Please read the reverse side of this form.

Your assistance with this is greatly appreciated. Thank you.

Student's Name: ________________________ Birthdate:__________ Grade:_____ School: __________________

Illness requiring medication: ____

Name of medication to be given to this student: ______________________________________

Dosage to be given:______________________ Time to be given/directions: ______________________

Route to be given: ______________________ How many days is medicine to be given?______________

Prescribing Health Care Provider's (Doctor, Dentist, etc.) Name:______________________________

Address: ________________________________ Health Care Provider's Phone #: __________________

List possible (significant) side effects of this medication: ______________________________

Allergies of student:____

Other Information / Comments: ____

STATEMENT OF PARENT/GUARDIAN

I hereby release and discharge Brookhaven Innovation Academy and its employees and officials, from any and all liability in case of accident or any other mishap in supervising/assisting with said medication due to any side effects, illness, or other injury which might occur to my child through supervising/assisting with said medication, and I hereby release said aforementioned officials from any liability because of any injury or damage that might occur.

Permission is hereby granted to the principal or his/her designee to supervise/assist my child in taking the indicated medication. I understand that a concerted, reasonable effort will be made to administer the medication listed above. (See reverse side for guidelines for all medication administration.)

I give the above mentioned personnel permission to contact my child's health care provider, if necessary, to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required. For lifesaving emergency medications, I give permission for school staff on a "need to know" basis be trained on administration of this medication for my child.

____ ______________________________

Signature of Parent/Guardian Date

Work Phone #:______________________________ Home Phone #: ______________________________

Cell Phone #:______________________________