Heritage Christian School

LICENSED PRESCRIBER'S ORDER FOR MEDICATION

Dear Parent/Guardian,

To comply with your request to administer medication to your child as prescribed by his/her licensed prescriber, you must agree to the following:

1. Written permission from custodial parent/guardian must be on file
2. You are responsible for the safe delivery of the medication in the container from the pharmacy to the school
3. You agree to notify the school immediately if there is as change in the use of the medication
4. You understand that we must have written directions from the licensed prescriber
5. You release the BOE and it's employees from any and all liability of injury or damages directly or indirectly from this authorization
6. You also give permission to the school personnel to contact the licensed prescriber with questions regarding medication orders and to send progress reports to clarify information

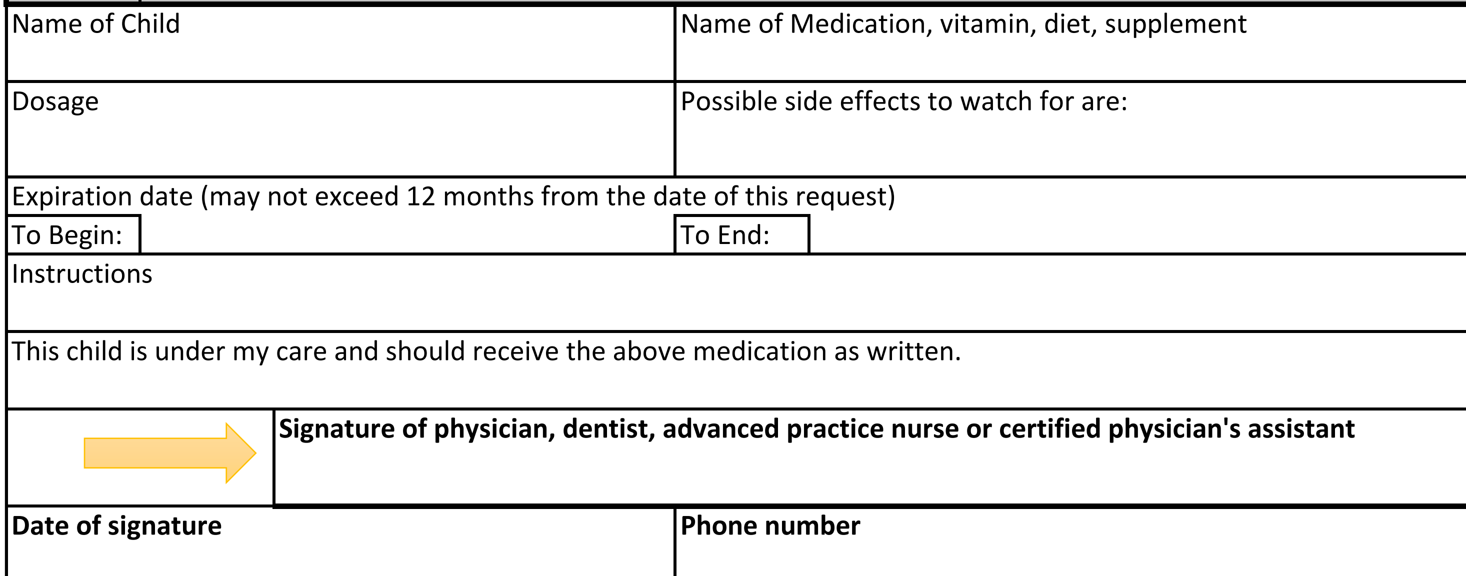
This form must be kept on file for 12 months following the last administration of the medication.
Note one form must be used for each medication ordered.

BOX 1	TO BE COMPLETED BY THE PARENT/GUARDIAN

Check all that apply:

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement
☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Age	Weight	Grade
Address		Phone ( )		
Name of Medication		Exact Dosage		
To be administered at the following times		For the folowing period of time		
☐ For daily routine medications, I understand that my child must receive one dose of medication before arriving at the program				
Signature of Parent/Guardian		Date		



BOX 2	TO BE COMPLETED BY A LICENSED PHYSICIAN, LICENSED DENTIST, ADVANCED PRACTICE REGISTERED NURSE OR CERTIFIED PHYSICIAN'S ASSISTANT

Name of Child	Name of Medication, vitamin, diet, supplement
Dosage	Possible side effects to watch for are:
Expiration date (may not exceed 12 months from the date of this request)	
To Begin:	To End:
Instructions	
This child is under my care and should receive the above medication as written.	
	Signature of physician, dentist, advanced practice nurse or certified physician's assistant
Date of signature	**Phone number**
Please note this form expires 12 months from the date of my signature.	

The medication, vitamin, diet supplement, or topical must be delivered to the school by the parent/guardian in the container in which it was dispensed by the licensed prescriber, OTC meds must be in original box.

Feb-23