INNOVATIVE ARTS ACADEMY CHARTER SCHOOL

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

To: School Nurse

Date: _____

My child, _____, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medicine in an appropriately labeled, original pharmacy container as well as all over the counter medication my physician as ordered.

Name of medication: _____

Prescribed dosage: _____

Time schedule: _____

Physician (please print): _____

Physician telephone number: _____

List of side effects of medication: _____

Diagnosis and necessity of medication during school hours: _____

_____

Expected duration of medication regime: _____

The student is excused from these activities while taking this medication:

Physical Education: _____ Other: _____

PHYSICIAN SIGNATURE: _____

PARENT/GUARDIAN SIGNATURE_____

** The student must carry his/her rescue Inhaler / Epineohrine auto-injector and has demonstrated that he/she can properly self-administer and accepts full responsibility for the administration of his/her emergency medication. Physician and Parent(s)/Guardian(s) initial here:

Prescriber/Physician: _____ Date: _____

Parent/Guardian: _____ Date: _____