Infinity Charter School Authorization for Administration of Medication

Complete and return this form if your child needs to take any medication during the school day.

No prescription or over-the-counter medications will be administered to any student without an order from a physician, along with signatures from the physician and the parent/guardian. All medications must be HAND DELIVERED to the school by the parent/guardian. Students MAY NOT hand-carry any medication to school.

All prescription medications MUST be in a pharmacy labeled container including the name and phone number of the pharmacy, the name of the student, the physician's name, the name of the medication, the currently prescribed dose, time of administration and the Rx number. All over-the-counter medication MUST be in the original manufacturer's container with the student's name written on the container. The school nurse is available to discuss your child's medication, Monday – Friday from 9:30 a.m. – 1:30 p.m.

Student's Name **Date of Birth** **Allergies to Medication**

I, _____, authorize Infinity Charter School to administer the medication listed below as prescribed. I do hereby release, discharge and hold harmless the Infinity Charter School, its agents and employees, from any and all liability and claim whatsoever for the administration of the medication to my child.

Parent/Guardian Signature **Date** **Parent/Guardian Phone Number (home/cell/work)**

TO BE COMPLETED BY THE PHYSICIAN:

Name of Medication:
Diagnosis (reason medication is prescribed):
Dose: **Route:**
If medicine is to be given "as needed" describe indications:
If medicine is to be given daily, at what time?
How soon can it be repeated?
List Significant side effects:
Length of time treatment is recommended:

Other Information (including other medications student is taking) _____

_____

Physician's Name (Printed) **Physician's Signature** **Date**

Physician's Office Address **Physician's Office Phone Number**

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