SUCCESS ACADEMY

Student
Health
Services

CAREER ACADEMY

Prescription Medication

This form is only valid for one school year.
Students are **not allowed** to carry medication on them or have it in their locker.

Studnets' name: _____ **DOB:** _____

I am the legal parent/guardian of the above named student and I am requesting permission for my student to take medication at intervals during the school day. I hereby give my consent and authorize the school nurse ot other designated school employee to dispense the following:

Medication	Dose	Time

Possible side effects _____

Date	Physician's Signature	Phone number

Parents Responsibilities:

1. Provide safe delivery of the medication to school.
2. Notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
3. Pick medications up on or before the last day of school or the medication will be destroyed.

By signing, I release and agree to hold Success/Career Academy, it officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Date	Parent/Guardian Signature	Phone number

Tracy Smith RN (O) 574-299-9800 (F) 574-288-6125

Thank you!