

**BURNHAM WOOD CHARTER SCHOOL DISTRICT  
AUTHORIZATION FOR SHORT TERM MEDICATION AT SCHOOL**

This form is intended for medications needed for less than 7 days. Parents requesting long term medication administration at school must have a medication permit signed by the prescribing physician.

Date: \_\_\_\_\_

STUDENT'S NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

LEGAL GUARDIAN: \_\_\_\_\_

DAYTIME PHONE: \_\_\_\_\_

NAME OF MEDICATION:  
\_\_\_\_\_

REASON FOR GIVEN MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC):  
\_\_\_\_\_

AMOUNT OF MEDICATION TO BE GIVEN: \_\_\_\_\_

TIME OF DAY MEDICATION IS TO BE GIVEN: \_\_\_\_\_

EXPIRATION DATE OF MEDICATION: \_\_\_\_\_

DATE TO **START** MEDICATION: \_\_\_\_\_

DATE TO **STOP** MEDICATION: \_\_\_\_\_

POSSIBLE SIDE EFFECTS:  
\_\_\_\_\_

STUDENT'S PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

**PARENTS: PLEASE READ CAREFULLY:**

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. *I will notify the school if the medication is discontinued or the dosage has been changed.* Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the Physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date and picking up all unused medication within one week. I understand this form is for short term use only, and if my child continues to need medications past 7 days, I will provide the school with a medication permit in a timely manner to avoid disruption of medication administration at school.

\_\_\_\_\_  
Legal Guardian Date

**PLEASE NOTE:**

- A SEPARATE PERMISSION FORM IS REQUIRED FOR EACH MEDICATION TO BE GIVEN.
- PARENTS ARE RESPONSIBLE FOR NOTING THE EXPIRATION DATE OF ALL MEDICATION. EXPIRED MEDICATION WILL NOT BE GIVEN AT SCHOOL
- ANY MEDICATION NOT PICKED UP WITHIN ONE WEEK OF THE END DATE ON THIS FORM WILL BE DESTROYED ACCORDING TO SCHOOL DISTRICT GUIDELINES.
- **ANY OVER-THE-COUNTER MEDICATION GIVEN EVERY DAY FOR 7 CONSECUTIVE DAYS MUST HAVE PHYSICIAN'S AUTHORIZATION.**