# The Bridge of Hope Academy

## Permission to Administer Prescription or Non-Prescription Medication at School

Student Name: ______________________________ DOB: _____/_____/_____
(Last) (First) (MI)

Type of Medication: ___________________ _____ Prescription _____Non-Prescription

Name of Medication: ______________________________________

Date to Begin Medication _____/_____/_____Date to End Medication _____/_____/_____

Time to be Given: ________ Amount to be Given: ___________

Reason medication is being given: ________________________________________________

Form of Medication

_____ Tablet _____ Capsule _____ Liquid _____ Inhalant _____ Other (list)_________________

Physician's Name: ____________________ Phone Number: __________________

Please list any other health related issues, including allergies: ____________________________

______________________________________________________________________________

______________________________________________________________________________

Any changes in their medication must be submitted in writing to the office so we may update their file.

______________________________ _____/_____/_____

Parent/Guardian Signature Date