1958 N. Road Street
Elizabeth City, NC 27909
newlifeacademyec.com

(252) 335-5812 office
(252) 334-9663 fax
nlacademyoffice@gmail.com

# PERMISSION TO ADMINISTER MEDICATION

Student Name: _____ Birthdate: _____

****Medication MUST be labeled by physician or pharmacist or be in original container.*

Date of Prescription: _____ Discontinue Date: _____

Disease, Illness or Injury: _____

Medication: _____

Reason that necessitates the medication be given during school hours: _____

_____

Daily: _____ PRN: _____ Emergency: _____

Strength: _____ Dosage: _____ Frequency: _____ Time: _____

Route of administration: _____

Intended effect of medication: _____

Side effects (from medication) student should be observed for: _____

_____

Other medication(s) student is receiving: _____

_____

Re-evaluation date: _____

May student self-administer medication under the supervision of Health Service personnel or designee?

Please circle one: YES NO

Directions for self-administration: _____