

PERMISSION FOR PRESCRIBED AND OVER-THE-COUNTER MEDICATION
(Only medications that are absolutely required during school hours will be administered.)

Name of Student _____ School _____

Grade _____ Medication _____ Dosage _____

Time of day medication is to be given _____

Purpose of Medication _____

Inhaler to be carried on person YES NO (Note: Only allowed for Grades 6-12)

Possible side effects _____

Anticipated number of days it needs to be given at school _____

Signature of Physician

Date

I hereby give my permission for _____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication, according to school procedures.

Signature of Parent or Guardian

Date

Note: The prescription medication is to be brought to school in the original contained, appropriately labeled by the pharmacy, or physician, state the name of the medication, the dosage, and the student's name. Over the counter medication must be brought to school in its original container with label intact.

Nurse's Comments: Specific directions to be followed (i.e., give with milk) or negative-response to be reported immediately (i.e., rash, vomiting, etc.) _____

Arrangement for Administering Medication to Student Unable to Self-Administer _____

Signature of Parent or Guardian

Date

Signature of School Nurse

Date