



To be completed by Physician for Prescription Medications

Name of Student _____ School _____

Medication _____ Dosage _____

Time(s) medication is to be given: a.m. ____ p.m. ____ To be given from (date) _____ to _____

Significant Information (include side effects, toxic reactions, omission reactions): _____

Contraindications for Administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school personnel are to:

- Contact me at my office _____ Phone _____
- Take child immediately to the emergency room at _____
- Other option _____

This medication will be furnished by the parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given).

Physician's Signature

Date

Physician's Address and Phone Number

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School and its employees from all liability that may result from my child taking the prescribed medication.

Parent or Guardian's Signature

Telephone Number

Date

(School Use Only)

Name and title of person to administer medication

Reviewed by

School Nurse's Signature

Date