School District School Year

MEDICATION PERMISSION AND **INSTRUCTION** Parents/Guardians -- please fill **out this section**

If it is necessary for your child to take medication (either non-prescription or prescription) during school hours, this form must be filled out each year and returned to the school office before school starts. (Prescription medication requires physician consent and signature. See below)

Student's Name _____ Birthdate _____ Grade _____

Parent/Guardian _____ Phone _____ Emergency Phone _____

Physician _____ Phone _____

Name of Medication/dose _____

Time given _____ Number of Days

Reason for medication _____

Side effects _____

All medications should be in original container which includes:

1. Student's full name
2. Name of drug, dosage and frequency
3. Name of physician
4. Pharmacy/phone number

If the medication also needs to be taken at home, your pharmacy can give you a second container.

I hereby authorize the designated school staff to supervise and/or dispense medication as noted above or outlined by physician. I will notify the school of any changes. I give my permission to communicate with child's physician when necessary. I further agree to hold the designated person(s) harmless in any and all claims arising from the administration of the medication at school.

Parent/Guardian Signature _____ Date _____

Physician -- **Please fill out this section**

Your consent and written instructions are required for this student to receive prescription medication at school. The permission and instruction must be given and signed each year.

	Medication	Dosage/Time to be Given	Side Effects
1.			
2.			
3.			

Comments:

_____

Physician Signature _____ Date Appendix A _____