

PARENTAL/GUARDIAN ADMINISTRATION OF MEDICATION PERMISSION FORM

(This permission form must be accompanied by written orders from the attending physician.)

Please complete the following information and enclose with *each medication* you send to school to be taken during school hours.

STUDENT NAME _____ **GRADE** _____ **HOMEROOM** _____

NAME OF MEDICINE _____

PRESCRIBED BY PHYSICIAN? No ___; Yes ___

NAME OF PHYSICIAN _____

INCLUDE THE DOCTOR'S WRITTEN ORDERS WITH YOUR PERMISSION FORM.

PRESCRIPTION NUMBER _____

NAME OF PHARMACY _____

DOSAGE _____ AT _____ (TIME) FOR _____ DAYS

LIST ALL CURRENT MEDICATION TAKEN BY THE STUDENT (home or school):

LIST ALL PROCEDURES TO BE DONE (at school)

I will take full responsibility for the prescribed medication, which is to be given during school hours.

Signature of Parent or Guardian _____ Date _____

Phone Number _____ (home)

Phone Number _____ (work)

The medicine container must be properly labeled with the student's name, homeroom, name of the medication and the time and dosage to be given.

Medications that do not comply with these guidelines will not be given by school personnel and will be returned to the parent or guardian.