MEDICATION PERMISSION FORM

No prescription medication will be given at school until the school nurse receives this completed form with the medication in a **container appropriately labeled by the pharmacy or physician. Non-prescription medications must be brought to school in their original container.**

Name of Student_____Date of Birth:_____

Please complete the appropriate section below for prescription or non-prescription medication. Please note: A physician's order is needed for administration of all Prescription medications in the school setting.

A. Prescription Medication:

Physician order:

Medication:_____

Dosage:_____Time to be given at school:_____

Specific Directions:_____

Relevant side effects to be observed if any:_____

Reason for giving:_____

Beginning date:_____

Signature of Physician:_____Date:_____

Parent Permission: I hereby give my permission for the above named student to take the medication as prescribed above.

Parent/Guardian Signature:_____Date:_____

B. NON-PRESCRIPTION MEDICATION (Other than for Tylenol or Ibuprofen as this is on the annual health questionnaire form)

Parent Permission: I hereby give my permission for the above named student to take the following medication:

Medication:_____

Dosage:_____Time to be given at school: _____

Specific Directions:_____

Reason for giving:_____

Beginning date:_____Termination date:_____

Parent/Guardian Signature:_____Date_____