PARENTAL REQUEST FOR PRESCRIPTION MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE:

Student's Name:_____ Grade:_____

I, the parent of the above named student, hereby request that the medication prescribed by my child's physician be administered to my child by the school nurse at the prescribed time below. This information may be shared with school staff. I agree to bring a supply of medication to the school and pick it up when it is no longer needed. **Permission for medication is effective only for the current school year and needs to be renewed for each subsequent school year.**

_____ _____
SIGNATURE OF PARENT DATE

_____ _____
ADDRESS PHONE NUMBER

PHYSICIAN'S STATEMENT:

It is necessary for _____ to have the following medication during school hours.
Student's name

MEDICATION: _____ **DOSAGE:** _____ **TIME/FREQUENCY** _____

Length of time for which medication is prescribed: _____

Diagnosis/condition for which medication is prescribed: _____

Purpose of Medication: _____

Possible side effects: _____

The following restrictions in daily activity should be in effect while student is taking this medication: (i.e.: labs, phys. ed., sports) _____

List other medication that student is taking which may interact with or alter the effect of this medication:

_____

Please check one of the following.

In the event of a field trip.

- ☐ The administration of this medication **may be postponed** until child returns to school.
- ☐ This medication **may be omitted** on the days when where is field trip.
- ☐ This medication **must** be administered at the above time.

I hereby authorize the school nurse to administer the above medication.

_____
M. D. Name (Please Stamp)

_____
_____
Address/Phone

_____ _____
M.D. Signature Date