

PERMISSION FOR ADMINISTRATION OF MEDICATION

PARENT/GUARDIAN SECTION:

Name of Student _____ Date of Birth _____

Allergies _____

Legal Prescribers'/Physicians' Name _____

Address _____ Phone _____

I request that my child receive the medication prescribed below during school hours as authorized by my physician.

Signature of Parent/Guardian _____ Date _____

Home Phone _____ Emergency Phone _____

LEGAL PRESCRIBER SECTION:

Diagnosis _____

Medication _____ Route _____ Dose _____

DAILY Time of Administration: _____

PRN Describe indication(s) for administration: _____

Time interval for repeat dosage: _____

Side effects: _____

Intervention for adverse reactions: _____

Other information: _____

Date prescribed: _____ Date discontinued: _____

Signature of Legal Prescriber _____

***** Medication prescriptions are effective for one school year only and renewal is required annually. All forms must be on file in the Health office *before* medication can be administered.**