MEDICATION ADMINISTRATION PERMISSION

Dear Parent/Guardian:

All medication, prescription or OTC (over-the-counter) shall be administered only upon written order of the prescribing physician and a written request of the parent. This will give permission for the nurse to administer the medication as directed.

Medication must be given to the nurse **only** in a **currently** labeled prescription bottle or OTC labeled packaging.

TO BE COMPLETED BY PHYSICIAN

Student: _____Date: _____ School Year: September ___ to June _____

Diagnosis/Purpose: _____

Name of Medication: _____

Dosage: (mg) _____

Specific time(s) to be given: _____ **(Daily ○ or ○ PRN) (circle one) ○ am / ○ pm**

Special circumstances of administration **(if PRN, specify frequency**): _____

Dates of Administration: _____

Specify **reportable** side effects: _____

Name of Physician **(print)** _____ Signature of Physician

Address of Physician _____ Date

Telephone # of Physician (_____)_____

TO BE COMPLETED BY PARENT/GUARDIAN

Student: _____ Date: _____

I hereby give permission to the school nurse to administer medication to my child as directed by the physician.

I release school personnel of all liability for the administration of medication as specified above.

Signature of Parent/Guardian

Date