



REQUEST TO TAKE PRESCRIPTION MEDICATIONS

Prescription medications given in school must be brought to the school in the ORIGINAL pharmacy container.

I, the parent/guardian of student: _____

Hereby grant permission for authorized St. Bernard Academy staff to give the medication described above, per the following schedule:

The container shall display:

- Child's Name
- Date
- Prescription Number
- Licensed Prescriber's Name
- Medication Name and Dosage
- Pharmacy Name, Address, Phone Number
- Administration Route or Other Directions

MEDICATION: _____

SCHEDULE: _____

SIGNED: _____ DATE: _____

Daytime phone number in case of emergency: _____



NON-PRESCRIPTION MEDICATIONS

All non-prescription drugs given in school shall be brought in with the manufacturer's original label with the ingredients listed and the child's name affixed to the container.

I give permission for St. Bernard Academy personnel to give my child,

Name: _____

Name of medication: _____

Dosage: _____ **Frequency and Time:** _____

Reason Medication is needed: _____

Signed: _____ **Date:** _____

Daytime phone number in case of emergency: _____