

PERMISSION FOR PRESCRIPTION MEDICATION

Date: _____ School: _____ Year: _____

Student: _____ DOB: _____ Grade: _____

Medication Name: _____ Medication Strength: _____

Medication Form: _____ Amount per Dose: _____
(Capsule, Tablet, Inhaler)Doses Submitted: _____ Diagnosis/Illness: _____
(Amount provided to school.)

Possible Side Effects: _____

Special Instructions for Secretary or School Nurse: _____

Physician Signature: _____ Date: _____

PARENT PERMISSION

I hereby give my permission for _____ to take the medication prescribed by our physician. I authorize the School Nurse to communicate with the above physician's office, if needed and may only include the prescription or treatment itself, implementation of the treatment in school and student outcomes of the treatment.

NOTE: The prescription medication is to be brought to school in the original container, appropriately labeled by the pharmacy.

Printed Parent/Guardian Name_____
Parent/Guardian Signature_____
Date_____
School Nurse's Printed Name_____
School Nurse's Signature_____
Date

Over-The-Counter (OTC) Medication Authorization Form

Student Name: _____ Date of Birth: _____ Grade: _____

Last

First

Medication Allergies: No _____ Yes _____ If Yes, Give name of Medication(s): _____

Describe Reaction: _____

OTC medications students may take while at school will be provided by the school nurse or secretary. Medications may be added or deleted from the authorization form at any time during the school year by contacting the School Nurse. With parental consent, the following types of OTC medication may be given to your child when needed. **Parents/guardians are to supply the medication to the office in it's original packaging.**

Please check "yes" to authorization school nurse/staff to give your child the following medication while on campus. OTC medications are dispensed per package directions unless written directives are provided by a physician.

Over-the-Counter Medication per package directions:	Dose	Indications:	Yes
Acetaminophen (Tylenol) or Generic		Pain reliever/fever reducer	
Diphenhydramine (Benadryl) or generic		Hay fever or upper respiratory allergies	
Cough drops or throat lozenges		Cough/throat irritation	
Calcium Carbonate (Tums)		Stomach pain	
Ibuprofen (Advil) or generic		Pain Reliever/fever reducer	
Other:			

I give permission for medication listed above to be given to my child for self-administration at the Nurse's discretion or dispensed by designated personnel as delegated by the School Nurse.

Parent signature

Date