



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 **must** display:

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

MEDICATION: _____

SCHEDULE: _____

Signed: _____ *Date:* _____

Phone number in case of emergency: _____



NON- PRESCRIPTION MEDICATIONS

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

I give permission for St. Bernard Academy's staff to give my child,

Name: _____

Name of medication: _____

Dosage: _____ Frequency Time: _____

Reason medication is needed: _____

Signed: _____ *Date:* _____

Phone number in case of emergency: _____