

PRESCRIPTION MEDICATION PERMISSION FORM

This form is to be downloaded, printed, and taken to the student's physician for a signature. Return the completed form to your student's school, in order to give the district permission to administer prescription medication at school.

Permission for the administration of prescription medications during school attendance:

Student name: _____ Student grade level: _____

Medication: _____ Dosage: _____

Reason for Rx: _____

Time of day to be given: _____

Anticipated duration of Rx at school: _____

Physician comments: _____

Physician signature: _____ Date: _____

Physician name (printed): _____ Phone number: _____

Parent/legal guardian signature* _____ Date: _____

**The signature of a parent or legal guardian is required* for all students in grades preK-12, in order to authorize school personnel to dispense prescription medication(s) at school.

RELEASE OF INFORMATION

With my signature above, I also hereby authorize the mutual release and disclosure of information regarding: medication and/or medical records (optional) between health care provider: _____ and the Eudora School District. I understand that the information disclosed will be treated in a confidential manner.

Note: Any prescription medication must be brought to school in the original container appropriately labeled by the pharmacy stating:

1. Name of the student
2. Name of the medication
3. Dosage and time to be administered
4. Number of days to be administered
5. Current prescription date