Mountain Lakes School District

PERMISSION TO ADMINISTER MEDICATION

PARENTAL/GUARDIAN PERMISSION

Authorization is hereby granted for the **school nurse** to administer medication as prescribed by the doctor to _____ for the purpose listed. Medication will be
Print name of child
provided by the parent/guardian in the original container labeled by the pharmacy with the child's name, date of birth, medication, and dosage and instructions for administration.

_____ _____
Parent/Guardian signature Date

Physician, physician assistant, or nurse practitioner must also complete this form.

Physician Permission

Date:_____

Student Name:_____ DOB:_____
Allergies:_____

Prescription #1

Diagnosis:_____

Medication:_____

Dosage:_____ Route:_____

Duration:_____
Side Effects:_____
Restrictions while taking medication:
_____
Self Administration: *yes:_____ no:_____

Prescription #2 *(If Needed)*

Diagnosis:_____

Medication:_____

Dosage:_____ Route:_____

Duration:_____
Side Effects:_____
Restrictions while taking medication:
_____
Self Administration: *yes:_____ no:_____

*Student has been instructed and observed in the correct self administration and carrying of indicated medication above.

Physician Stamp

_____
Physician signature

MEDICACIONES

PERMISO DE PADRE/TUTOR
Doy permiso para que la enfermera escolar administer medicacion a _____
Segun fue recetada por:
DR:_____ por larazon indicada:_____

El padre/tutor proveera esta medicacion con la medicacion recetada y la dosis del estudiante claramente anotada en la etiqueta.

_____ _____
Padre/tutor Fecha

Physician, physician assistant, or nurse practitioner must also complete this form.

Physician Permission

Date:_____

Student Name:_____ DOB:_____
Allergies:_____

Prescription #1

Diagnosis:_____

Medication:_____

Dosage:_____ Route:_____

Duration:_____
Side Effects:_____
Restrictions while taking medication:
_____
Self Administration: *yes:_____ no:_____

Prescription #2 *(If Needed)*

Diagnosis:_____

Medication:_____

Dosage:_____ Route:_____

Duration:_____
Side Effects:_____
Restrictions while taking medication:
_____
Self Administration:* yes:_____ no:_____

*Student has been instructed and observed in the correct self administration and carrying of indicated medication below.

Physician Stamp

_____ Physician signature