Washington International School
3100 Macomb Street NW ● Washington, DC 20008
MS/US Nurse 202.495.7301 ● PS Nurse 202.243.1709

PRESCRIPTION CONSENT FORM

Name of student _____ Grade _____

Name of Physician _____ Phone _____

Prescription Medication _____

Reason for Treatment _____

Time of administration _____

Dosage of medication to be given _____

Dates to be given _____

Possible side-effects _____

Signature of Parent *_____ Date _____

Daytime phone(s) _____

Signature of Physician _____ Date _____

Address of Physician _____ Phone _____

*This signature also authorizes the School Nurses to contact the Physician if need arises.

Medication must be in a container label by the Pharmacist with the following:

- Child's full name
- Name of medication
- Dosage
- Frequency of administration
- Physician's name
- Date dispensed
- Expiration date
- Medication must be collected within one week of expiration (or the end of the school year) or it will be discarded.
- Additional instructions (e.g., with meals, with juice, or water)

School or Health Office personnel will not assume any responsibility for unauthorized medication/ treatment that students give to themselves.