



Nellie H. Stokes Elementary School

Main Office: (302) 697-3205 Main Office FAX: (302) 697-4029
Nurse Jessica Lynch, MSN, RN
Nurse's Office: (302) 697-4026 Nurse FAX: (302) 697-4029

Mrs. Kerri Carr, Principal
3874 Upper King Rd. Dover, DE 19904

Parental Request/Permission to Have Medication Administered in School and on Field Trips

If it is necessary for your child to receive medication during the school day, please complete the following: ○

Send the medication with a responsible individual if you are unable to take it to school. ○ Send the medication in the original container. If a prescription, the container must be properly labeled with the correct name, time, dose, date, and prescribing licensed healthcare provider.

- Count the tablets or approximate amount of liquid in the bottle.
- A request/permission form must be completed for **each** medication.
- Pick up the medication from school at the end of the school year. Epi-pens and inhalers may be sent home with students in middle and high schools.

Date: _____

Student's Name: _____

Medication: _____ Expiration Date: _____

Dose: _____ Time: _____

Reason for Medication: _____

Known Allergies: _____

Number of tablets sent: _____

Amount of liquid sent: _____

Prescribing Provider: _____

I am aware that the school nurse may need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and that he/she is required to use nursing judgement regarding all medication administration. I give my permission for medication administration by the school nurse.

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

I request that afternoon medications be administered during half-days. Initials: _____

Field Trip Permission:

I give permission for a trained staff member to assist my child with self-administration of his/her medication on field trips.

Guardian Signature: _____ Date: _____

Refills and Counts

(to be completed by RNs)

[illegible]