



THE
STANLEY CLARK
SCHOOL

Permission for Prescription Medications

Parent or guardian and *physician signature* required

Student Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____

PLEASE NOTE THE FOLLOWING:

1. All medications must appear EXACTLY as written on the original medication container.
 2. All medications MUST be brought to school in the original container.
 3. The original container MUST identify the name of the medication, concentration, dosage and frequency of administration.
 4. Parent will assume responsibility for safe delivery of the medication to school.
 5. Parent will notify the school immediately if there is any change in the dose of the medication or the prescribed treatment.
 6. Medications must be picked up at the end of school year by parent, or medication will be destroyed.
- _____

Medication 1: Name _____

Dosage: _____ Route: _____ Time of Administration: _____

Self Carry?: ☐ **Yes** ☐ **No**

Self - Administer? ☐ **Yes** ☐ **No**

Medication 2: Name _____

Dosage: _____ Route: _____ Time of Administration: _____

Self Carry?: ☐ **Yes** ☐ **No**

Self - Administer? ☐ **Yes** ☐ **No**

If yes, I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent authorization must be submitted.

Physician Signature: _____

Date: _____

Parent Signature: _____

Date: _____