



OFFICE OF SCHOOL NURSE
7280 Frenchman's Bay
St. Thomas, VI 00802
340-776-1600 x 4603
FAX: 340-776-1019
nurse@antilles.vi

PRESCRIPTION (RX) MEDICATION RELEASE FORM

Dear Parents/Guardians,

Antilles School discourages dispensing medication to students during the school day. However, if your physician determines it is necessary for your child to receive prescription medication during the hours your child is in attendance at Antilles, specific directions and approval accompanied by a physician's signature must be provided to Antilles School prior to dispensing of any prescription medication at school. For the safety of all children, **no prescription medication will be dispensed or permitted at Antilles School without detailed directions and specific physician's approval for such distribution.** For your child's safety, it is strongly recommended that the initial dose(s) of any medication be administered by the physician or at home.

If a child must take medication during the school day, the Parent/Guardian must do the following:

1. Physician must provide specific, written instructions for administering any and all prescription medication(s) for your child to Antilles School prior to dispensation of first dosage scheduled during the time child is in attendance at Antilles School.
2. Take this form to your family physician to record instructions for dispensing medication to your child along with physician's signature of approval.
3. Parent/Guardian must deliver any and all medication(s) prescribed for their child/children to the Antilles School nurse or school personnel along with this form completed by physician prior to dispensation of first dosage scheduled during the time child is in attendance at Antilles School.
4. Any and all medication must be in the original box or container with the current prescription label. Upon request, pharmacists will provide a "duplicate" container for this purpose.
5. All students who require an Epi Pen or Inhaler must have this form filled out by their physician with proper instructions. If the student (4th through 12th grade) can have the Epi Pen or Inhaler on their person please indicate approval.

| | | | |
|---------------------|-------|--------|----------------|
| Student's Last Name | First | Middle | Usually Called |
|---------------------|-------|--------|----------------|

| | | | |
|---------------|---------------|-----|-----|
| Current Grade | Date of Birth | Age | Sex |
|---------------|---------------|-----|-----|

| | | |
|--------------|-----------------------|-----------------------|
| Home Address | Home Telephone Number | Cellular Phone Number |
|--------------|-----------------------|-----------------------|

| | | | |
|---------------------------|------|---------------------------|------|
| Parent/Guardian Signature | Date | Parent/Guardian Signature | Date |
|---------------------------|------|---------------------------|------|

Physician's Directions for Dispensation of Prescription Medication:

| | | |
|------------------|----------------|------------------------------|
| Physician's Name | (PLEASE PRINT) | Physician's Telephone Number |
|------------------|----------------|------------------------------|

| | |
|-----------------------|------|
| Physician's Signature | Date |
|-----------------------|------|