PHYSICIAN'S RECOMMENDATION FOR ADMINISTERING PRESCRIPTION MEDICATION

We are aware that at times it may be necessary for a student to take prescription medications while at school. It is preferred, if possible, that medication be administered at home. In the event it is absolutely necessary that the student take medication during the school day, this form must be completed and signed by the physician prescribing the medication. The form must also be signed by the parent or guardian before the student can begin taking the medication at school.

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Physician's Prescriptive Directions: Please describe the medicine, the dosage, at what time it should be administered, the purpose of the medication and anticipated amount of time on medication.

Patient's Name: _____

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

_____

_____

_____ _____

Physician Signature Date

Parent Information/Permission: The staff responsible for _____ has my permission to assist with self-administration of the medication as prescribed by above physician.

_____ _____

Parent/Guardian Signature Date

Parent/Guardian: Please list below any medications not listed above that are taken at home whether they are prescription or over the counter medications. This information is required in the event of an emergency medical situation while at school. Before emergency medical services can be performed it is important to know what medication the child may have taken that day.

Name of Medication	Dosage	Time

PARENT REQUEST FOR ADMINISTERING OVER THE COUNTER MEDICATION

We are aware that at times it may be necessary for a student to take over counter medications while at school. It is preferred, if possible, that medication be administered at home. In the event it is absolutely necessary that the student take medication during the school day, this form must be completed and signed by the parent or guardian before the student can begin taking the medication at school.

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Medication Directions: Please describe the medicine, the dosage, at what time it should be administered, the purpose of the medication and anticipated amount of time on medication.

Patient's Name: _____

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

_____

_____

Parent Information/Permission: The staff responsible for _____ has my permission to assist with self-administration of the medication as prescribed by above physician.

_____ _____

Parent/Guardian Signature Date

Parent/Guardian: Please list below any medications not listed above that are taken at home whether they are prescription or over the counter medications. This information is required in the event of an emergency medical situation while at school. Before emergency medical services can be performed it is important to know what medication the child may have taken that day.

Name of Medication	Dosage	Time