Parental Request for Prescription Medication to be Administered by School Nurse

Student's Name_____________ Grade_______

I, the parent of the above named student, hereby request that the medication prescribed by my child's physician be administered to my child by the school nurse at the prescribed time below. This information may be shared with school staff. I agree to bring a supply of medication to the school and pick it up when it is no longer needed. Permission for medication is effective only for the current school year and needs to be renewed for each subsequent school year.

Signature of Parent_______________________ **Date_____________**

Physicians Statement:

It is necessary for __________________________ to have the following medication during the school hours.

Medication:___________________________________ Dosage:______________ Time/Frequency:_____________

Length of time for which medication is prescribed:____

Diagnosis/Condition for which medication is prescribed:____

Possible side effects:____

The following restrictions in daily activity should be in effect while student is taking this medication:____________

____.

List other medications that student is taking which may interact with this medication._______________

____.

Please Check one of the following.

In the event of a field trip:

____The administration of this medication may be postponed until student returns to school.

____This medication may be omitted on the days when there is a field trip.

____This medication must be administered at the above time.

I hereby authorize the school nurse to administer the above medication.

_______________ _________________ ______________

M.D. Name(stamp) **M.D. Signature** **Date**