Anaconda School District #10
Special Services / Nursing Department
515 Main Street
Anaconda, MT 59711

PERMISSION FOR MEDICATION

Name of Student _____ **DOB** _____

School _____ **Grade** _____ **Teacher(s)** _____

Medication _____ **Dosage & Route** _____

Time(s) of day medication is to be given _____

Purpose of medication _____

Possible side effects _____

Anticipated number of days medication needs to be given at school _____

_____	_____	_____
Physician Name (Printed)	**Physician Signature**	**Date**

As parent or guardian, I hereby give my permission for the above named student to take the prescription listed above at school as ordered. I understand that it is my responsibility to furnish this medication.

_____	_____	_____
Parent / Guardian Name (Printed)	**Parent / Guardian Signature**	**Date**

Note: The prescription medication is to be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy or physician, stating the name of the student, the name of the medication, the medication dosage and administration time(s).

Permission form received and reviewed by the school nurse:

_____	_____	_____
Name of School Nurse (Printed)	**School Nurse Signature**	**Date**

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