Central Elementary School

Parent's Request for Giving Prescription Medicine at School

I authorize the school nurse or school personnel, under the supervision of the school nurse, to be my agent to give the following medication to my son/daughter:

Student Name: _____ Grade: _____

Teacher/Homeroom: _____

Name of Medication: _____

Condition for which medication is to be given _____

Dosage: _____ Time to be given: _____

To be given for the period from _____ to _____
(date) (date)

The medication should be delivered by an adult to the school nurse. It must be in a properly labeled (pharmacy label) container with the student's name, the physician's name, date of original prescription, and name of medicine.

ALL MEDS WILL BE GIVEN AS DIRECTED ON THE PRESCRIPTION LABEL. IF THERE IS A CHANGE IN THE PRESCRIPTION DOSE OR TIME SCHEDULE, PLEASE HAVE THE PHYSICIAN FAX OR PHONE THE NEW PRESCRIPTION TO THE SCHOOL.

_____ _____
Parent/Guardian Signature Date

4/2013 SGH