COLUMBIA BOROUGH
SCHOOL DISTRICT

"Responsible Caring Citizens serving Responsible Caring Citizens"

MEDICATION POLICY INFORMATION FORM
TO BE COMPLETED BY PARENT AND PHYSICIAN

ALL medication, including over the counter medication, **MUST** be delivered to the school's Health Room by the parent or guardian.

ALL medication, including over the counter medication, **MUST** be in the original container. The Policy also requires that the following information must be supplied in order that medication may be taken by your child at school.

NOTE THAT PARENT/GUARDIAN'S AND PHYSICIAN'S SIGNATURE ARE REQUIRED.

Student's Name: _____ Grade _____
Prescribing Physician's Name: _____
Name of Medication: _____
Purpose of Medication: _____
Dosage of Medication: _____
Time of day Medication is to be given: _____
Possible Side Effects: _____
Date to Begin: _____

I understand that my child is responsible for taking the medication. I hereby request and give permission to the nurse to administer the **prescribed &/or OTC** medication to my child.

_____ _____ _____ _____
Prescribing Physician's Signature Date **Parent/Guardian's Signature**
Date

Columbia Borough School District
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