

Medication Permission Slip

Medications prescribed for an individual student **MUST** be kept in the original container bearing the original pharmacy label with student's name, medication, and dosage. **NO medication (prescribed or over the counter) shall be dispensed without written permission of the physician and legal guardian of the student.** The pharmacy label can serve as the written order of the physician. Changes in medication must be documented by written authorization from the physician. **Medication cannot be transported by students in grades k-8.**

Name of student _____

Name of medication _____

Dosage _____ Time _____

Pharmacy _____ Prescription # _____

To Be Completed By The Physician

It is necessary for this medication to be taken during the school day at the above time(s).

Physician's name _____

Address _____ Telephone _____

Physician's signature _____ Date _____

To Be Completed By The Parent

I authorize school personnel to administer the above medication to my child and agree that we will not hold liable any member of the school staff or an individual of official capacity who is directed by me and the school nurse to assist my child in taking said medication.

Parent/Guardian signature _____ Date _____

Home Address _____

Home Telephone _____ Work Telephone _____