TO BE COMPLETED BY PHYSICIAN

Student’s Name:_________________________________________________
Reason for medication:_____________________________________________
Medication:____________________ Dose:___________ Time:___________
Other times of the day this medication is given:________________________
Dose:____________
If the morning dose is missed at home, may it be given at school at parent’s request?  
  ___Yes  ___No
Administration date: Begin:_________________________ End:____________________
Possible Side effects:_______________________________________________
This student is under my medical care and requires medication during school hours.
Physician’s Stamp: Date:________________________

TO BE COMPLETED BY PARENT/GUARDIAN

As the parent/legal guardian of the student listed above, I authorize the school nurse  
to administer this medication during school hours as prescribed. I understand that all  
medication must be brought to school with the written prescription on the container.  
Over the counter drugs must be sent in their original container. No medication will be  
given without the written permission of the physician and the parent/legal guardian.  
Permission must be renewed each school year. I shall reclaim any unused medication  
by the last day of the school year or it will be disposed by the school nurse.

_______________________________________  ____________________
Parent/Legal Guardian Signature Date