



Permission for Prescription Medications

Summer Explorations

Parent or guardian and **physician signature** required

Student name

Date of birth

Parent name

Parent name

Current medications* child takes including drug name, dosage, route, time(s) of day and if taken with food.
Are these medication(s) to be administered at school? Yes No

Medication 1: _____ Taken with food? Yes No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? Yes No

Self-administer? Yes No

Medication 2: _____ Taken with food? Yes No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? Yes No

Self-administer? Yes No

Medication 3: _____ Taken with food? Yes No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? Yes No

Self-administer? Yes No

If yes, I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, I understand that a revised written physician's statement and parent authorization must be submitted.

Parent/Guardian Signature

Date

Physician or Nurse Practitioner Name

Phone

Physician or Nurse Practitioner Signature

Date

* A signature is required for all medications unless prescribed for a short-term (i.e. Amoxicillin for 10 days; pharmacy-labeled bottle with suffice.)