FORM FOR PRESCRIPTION MEDICINE

SCHOOL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIANS INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

NAME OF CHILD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_ GRADE: \_\_\_\_\_\_

DATE OF ORDER: \_\_\_\_\_\_\_\_\_\_ NAME OF DRUG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOSE: \_\_\_\_\_\_\_\_\_\_

TIME (and/or circumstance of administration at school): \_\_\_\_\_\_\_\_\_\_

CAN A REACTION BE EXPECTED (check one): \_\_\_ YES \_\_\_ NO (if yes, describe below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT SHOULD BE DONE? \_\_\_\_\_\_\_\_\_\_

HOW LONG IS MEDICATION TO BE CONTINUED? \_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_

I give my permission for this medication to be administered to my child by school personnel. The medicine is in the original container, labeled for my child.

PARENT OR GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_