SOUTHMINSTER SCHOOL

Long Term Medication Form

Physicians - Parental Permit to Administer Prescription or Non Prescription Medication
at school for more than 10 days,
for frequent use of as-needed medications (Tylenol, Advil, etc…),
or for medication to be kept at school for a health condition.

Student Name: Last	First	Date of Birth	Age
Grade	Teacher	Allergies	
Reason student receiving medication			
Name of Medication	Dosage	Time	
Possible toxic reactions			
Form of Medication ☐ Tablet ☐ Capsule ☐ Liquid ☐ Inhalant ☐ Other			
Feedback Requested ☐ Yes ☐ No	Date to be discontinued		
Physician Signature	Date	Telephone	
This is the school's permission to give (Student Name)			
The above medication as prescribed by Doctor _____ as he/she directs. This includes permission for communication between the school nurse and the prescriber.			
Parent/Guardian Signature	Date		
Telephone: Home	Cell	Work	

Parent/Guardian Signature Date

Parent/Guardian Signature Date

Parent/Guardian Signature Date