PERMISSION FOR MEDICATION TO BE GIVEN AT MONFORTON SCHOOL

Please Print Clearly

Student Name: ______________________________ Grade ________

Teacher: ______________________________

Diagnosis: ______________________________

Medication: ____________________ Dosage: ______________

Purpose of Medication: ______________________________

Time of Day Medication is to be Given: ______________________

Possible Side Effects:

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Anticipated Number of Days it Needs to be Given at School: ____________

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Additional Instructions: ______________________________

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______________ (Date) ______________________________ (Signature of Health Care Provider)

I hereby give my permission for ______________________ (student name) to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication. I authorize the release and exchange of information concerning this medication between my child's physician and the school.

______________ (Date) ______________________________ (Signature of Parent/Guardian)

Note: The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy, or Health Care Provider, stating the name of the student, the name of the medication, and the dosage.