PERMISSION TO GIVE MEDICATION AT SCHOOL

Edison Local Schools

Student last name First Middle age grade DOB

*****TO BE COMPLETED BY PHYSICIAN*****

Name of Medication Dosage Method Time Reason

Side Effects:

Precautions/Special directions:

If PRN, list symptoms

Signature of MD, NP/PA& Supr. MD

****TO BE COMPLETED BY PARENT/GUARDIAN****

My child is under the care of Dr. _____. I understand it is my responsibility as the parent/guardian to keep the school supplied with and informed of any changes in my child's medications. I, or a designated adult, will bring the medication to the school in its original container or prescription bottle. I also understand it is my responsibility to monitor expiration dates of all prescription or over-the-counter medications I bring to school. I authorize the school nurse to communicate with the health care provider when necessary.

I give permission to _____School to administer medication to my child,

(child's name)_____

Parent/Guardian (Print)_____Signature_____

Home phone:_____cell or work_____

Date:_____