Parental Request to Have Prescription Medication and

Treatment Administered at School

- Send the medication to school with a responsible adult
- Send the medication in the original container properly labeled with correct name, time, dose and date
- Count the tablets or give an approximation of the amount of liquid in the bottle
- Fill out the following information in full

Date: _____

Student's Name: _____

Medication: _____

Dose: _____ Time: _____

Doctor Prescribing Medication:_____

Reason for Medication:_____

Allergies/Health Concerns:_____

Number of Tablets:_____

Amount of Liquid:_____

I am aware it may be necessary and give permission by signing below for the school to contact my child's physician or pharmacist, if necessary, to provide medication/treatment for my child. If I have any questions, I will contact the school nurse at 302-678-3247

Parent/Guardian Signature:_____

Nurse's Signature:_____

Number of Tablets or Amount of Liquid:_____

☐ Check box if medication is to be administered daily and is to start at once.