**Parental Request to Have Prescription**

**Medication/Treatment Administered in School**

If it is necessary for your child to receive medication during the school day,

please do the following:

• Send the medication to school with a responsible individual if you are unable to take it to school.

• Send the medication in the original container properly labeled

with correct name, time, dose and date.

• Count the tablets (unless the number of tablets is the exact number on the label) or approximate amount of liquid in the bottle.

• Fill out the following information:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose/ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Medication ­­­­­­­­­­­­­­­­­: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to any medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of tablets sent:\_\_\_\_\_\_\_\_\_\_ Amount of liquid:\_\_\_\_\_\_\_\_

My signature allows the school nurse to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse’s Signature

Number of tablets/amount of liquid received