Prescriptions/ OTC Medicine Form

Students who need to take prescription medication OR non prescription/over-the-counter medication *during the school day* **MUST** have a completed medication form signed by their parent/guardian on file & have left *the approved medication in the school office/secured health area*. The previously approved medications will be dispensed as directed by the parent/guardian in the office.

STUDENT Name: _____GRADE_____

-I understand that by signing this form, I give permission and consent to the properly trained/designated administrative office staff or educator to assist my child in the administration of the medication listed below.

- If my child has a clinical health condition (e.g., severe food allergies, asthma, diabetes, or seizures), I am responsible for submitting a Care Plan which stipulates special needs prior to the first day of school.

Signed by (Parent/Guardian)_____ DATE_____

SPECIAL INSTRUCTIONS:_____

_____

_____

_____

_____

_____

_____

TYPE of medication (Name):_____

Amount of medication (Dosage):_____

Time of day to be administered:_____

Duration of use:_____

Prescribing Physician:_____

DR. Office Phone :_____

Special instructions for storing medication:_____

Instructions for aftercare of child once medication is taken:_____