

**PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM
TO BE FORWARDED TO THE SCHOOL NURSE**

Date _____

I hereby give my permission to _____ to release
(Physician's Name)
information to _____ concerning medication
(School's Name)
prescribed for _____.
(Name of Student)

Signature of Parent or Guardian _____

Medication _____

Directions _____

Beginning Date _____ Last Dose _____

Reason for Giving _____

Signature of Physician _____

I hereby give my permission for the above named student to take the medication as prescribed above at school.

Signature of Parent or Guardian _____

No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled by the pharmacy or physician.

All medicine brought into the school must be kept in the Health Room during school hours.

Date Received _____ Signature of School Nurse _____