

Prescription Medication Order & Permission Form

Student Name: _____ D.O.B: _____

Medication/Dosage: _____

Directions: _____

Beginning date: _____ End date: _____

Reason for giving: _____

Signature of Primary Care Provider: _____

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

Signature of parent/guardian: _____

Date Received: _____ School Nurse: _____

*****All medication brought into school MUST be kept in the Health Office during school hours*****