



## Prescription Medication Form

*This form must be completed by your child's PHYSICIAN if prescription medicine has to be administered WHILE YOUR CHILD IS IN SCHOOL.*

Exhibit: JHCD-E(1)

### Permission for Medication

Name of Student: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

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

Dosage: \_\_\_\_\_

Directions: \_\_\_\_\_

Reason for Giving: \_\_\_\_\_

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

\_\_\_\_\_  
(Signature of Physician)

I hereby give my permission for: \_\_\_\_\_ to take the above prescription at school as ordered.

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

\_\_\_\_\_  
(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.

(Physician and parents understand that, should school nurse be unavailable, school personnel have permission to administer above medication)