# MEDICATION CONTROL FORM FOR SCHOOL

Student Name_____Age_____

School_____Grade_____

Prescribing Physician_____

Purpose of Medication_____

Prescription_____
Name Dosage Frequency

Times of School Administrations_____

Comments Regarding Prescriptions (Side Effects, Adverse Reactions, etc)

_____
_____
_____
_____
_____

Physician or Nurse Signature_____Date_____

I hereby request that my child be administered his/her prescribed medication at school under the supervision of a designated medication dispenser. I understand that the medication will be administered as per the directions of the above named physician. I will notify the school in writing of changes or discontinuation of this medication. I will comply with school policy to personally deliver the medication with appropriate pharmacy labeling to the designated medication dispenser. **NO MEDICATIONS**, including psychostimulants, **are to be in the personal possession of the student at any time.** I give my permission for exchange of written/verbal information between the school, child's physician, and also Public Safety Officials to be valid for one (1) year.

Parent/Guardian
Signature_____Date_____

Address_____

Telephone_____