

## PERMISSION FOR ADMINISTERING MEDICATION AT SCHOOL

Children sometimes need to receive medications while at school. PRESCRIPTION medications require written instructions from a physician and written permission from the parent or guardian. NON-PRESCRIPTION medications require only written permission from the parent or guardian. **Please do not allow children to bring prescriptions or over-the-counter medicines to school to take without supervision. Medications cannot be self-administered and must be kept in the Lower School Office.**

**Physicians Instructions:** This requirement is met by bringing the medicine to school in the original pharmacy container labeled with the child's name, dosage and frequency to be given.

**Written Parental Permission:** This requirement is met by providing the following information:

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Name of medicine: \_\_\_\_\_ Dosage to be given: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_ Prescription number: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Medical condition for which this treatment is given: \_\_\_\_\_  
 Dates to be administered: \_\_\_\_\_ Time to be administered:     Lunchtime     As needed

Please indicate the number of tablets or amount of medication being provided for use at school. \_\_\_\_\_

**Oregon Episcopal School has my permission to administer the above medication to my child according to the above instructions.**

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Staff Signature \_\_\_\_\_ Initial \_\_\_\_\_      Staff Signature \_\_\_\_\_ Initial \_\_\_\_\_  
 Staff Signature \_\_\_\_\_ Initial \_\_\_\_\_      Staff Signature \_\_\_\_\_ Initial \_\_\_\_\_