

MEDICATION PERMISSION AND INSTRUCTION FORM
David City Public Schools
David City, NE

PRESCRIPTION

STUDENT NAME _____ GRADE _____

SCHOOL _____ TEACHER _____

We encourage the administration of medication at home. However, if your physician decides it is necessary for your child to receive a medication during the school day, **the following must be completed before any medication can be given.** It is recommended that the first dose of medication be administered at home. Most medication ordered three times daily can be given before and after school and at bedtime.

Medication must be brought to school in the original container as dispensed by the pharmacist or physician. Any changes in this information will require a revised written physician's statement, as well as a properly labeled container.

THIS PORTION TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

*Date of Order _____ *Discontinuation Date: _____

*Name of Medication: _____

*Dose: _____

*Time: _____

Possible Side Effect of Medication: _____

Telephone Number: _____

Physician/Provider Signature

Type/Print Physician/Provider Name

***For Over-the-Counter medication parents must complete the asterisk information.**

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give my permission for school personnel to administer medication during the school day to my child. This information may be mutually shared between the prescriber and the school.

DATE: _____

PARENT/GUARDIAN SIGNATURE

PHONE #: _____

Work