



Guidance & Health Services

Physician's Statement for Administration of Prescription Medication

Student's Name _____ Birthdate _____

School _____ Grade _____

It is necessary that the following medication be administered during school hours as specified below in order to maintain this child's physical health and support school performance.

NAME OF MEDICATION _____ DOSAGE _____

TIME _____ FREQUENCY OF USE _____

- Tablet Liquid Drops
- Capsule Inhalation Ointment
- Other (specify) _____

Condition for which medication is prescribed: _____

Medication may cause: _____

Emergency instructions: _____

Physician's Name (Please Print) _____

Signature of Physician (Original) _____

Address _____

Telephone _____

Date _____

I hereby grant permission for the school nurse or other school personnel to administer medication to my child according to the physician's statement given above.

Signature of Parent/Guardian _____

Date _____



Important Information for Parents/Guardians:

Medication must be prescribed by a licensed physician and appropriately labeled in the original container by the pharmacy or physician.

This statement must also be completed by a physician and parent/guardian when container labels on non-prescription medications do not specify dosage instructions appropriate for the child's age.

