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BADER HILLEL ACADEMY

PRESCRIPTION DRUG AUTHORIZATION 2019-20

To School Personnel:

I, _____ am requesting that _____
Parent/Guardian Name of Child

receive prescription drugs as designated below by his/her physician at the time indicated.

I will be responsible for bringing the prescription drugs to school in the container from the pharmacist. I also understand that **I am responsible for maintaining a sufficient quantity of the medication at the school** to avoid any interruptions in the physician's orders. Failure to do this will result in the termination of the school's administered medication program.

I understand that if my child refuses the prescription drugs, force will not be exerted to make him/her comply.

_____ _____ _____
Parent/Guardian Signature Relationship to Child Date

_____ _____ _____
Physician's Signature Address & Phone Date

Name of Medication	Dosage	Form (Pills, liquids, etc)	Time (am/pm)	Possible Side Effects

PARENT REQUEST FOR GIVING NON-PRESCRIPTION (OVER THE COUNTER) MEDCATION AT SCHOOL

I request that the school nurse or the principal's designee see that my child _____
Receives the non-prescription medication indicated below. The medicine is to be delivered to the school by the parent and the information below is to accompany the medicine.

Name of Medication	Dosage	Form (Pills, liquids, etc)	Time (am/pm)	Possible Side Effects

_____ _____
Parent/Guardian Signature Date