

## PRESCRIPTION DRUG AUTHORIZATION

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) MEDICATION 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