



Prescription Medication Form

Dear parent/guardian: We understand that the administration of medication during the school day is sometimes unavoidable. Please note the following:

- For your child to receive prescription medication or OTC medications not listed on the school's standing orders during the school day, the information below must be completed by parent **and physician**.
- All medication must be provided by you and must be in the **original container with your child's name clearly marked.**
- **Medication must be brought in by the parent/guardian.** Do NOT send medication in with the child.
- Dispensing of all medication is documented by the school nurse.

Parent/Guardian Consent:

- I give permission for my child, _____, to receive the medication listed below during the school day.
- I understand that the medication will be given by the school nurse according to my child's physician's directions.
- I agree to release DCA of any liability and hold DCA harmless for the administered of the medication(s) noted below.

Signature of Parent/Guardian

Date

Licensed Prescriber Medication Order:

Patient's Name _____

Name of Medication _____

Dosage _____ Route _____ Time of Administration _____

Reason for Medication _____

Possible side effects/Interactions with other medications _____

Physician Name _____ Physician Signature _____

Date _____

(Space for additional medication orders are located on reverse side of this form)

Licensed Prescriber Medication Order:

Patient's Name _____

Name of Medication _____

Dosage _____ Route _____ Time of Administration _____

Reason for Medication _____

Possible side effects/Interactions with other medications _____

Physician Name _____ Physician Signature _____

Date _____

Licensed Prescriber Medication Order:

Patient's Name _____

Name of Medication _____

Dosage _____ Route _____ Time of Administration _____

Reason for Medication _____

Possible side effects/Interactions with other medications _____

Physician Name _____ Physician Signature _____

Date _____

Licensed Prescriber Medication Order:

Patient's Name _____

Name of Medication _____

Dosage _____ Route _____ Time of Administration _____

Reason for Medication _____

Possible side effects/Interactions with other medications _____

Physician Name _____ Physician Signature _____

Date _____