



# Prescription Medication Form

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Return this form  
when necessary –  
make copies as  
needed.

I request and hereby give permission to school personnel to give the prescription medication to my child named below as requested by the physician.

\_\_\_\_\_  
Child's name

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Telephone number

## Physician's Statement

\_\_\_\_\_  
Child's name

\_\_\_\_\_  
Date

In order that this school child remain in optimum health and to help maintain maximum school performance, it is necessary that the following medication be given during school hours.

\_\_\_\_\_  
Name of medication

\_\_\_\_\_  
Dosage to be given (amount)

Form of medication:     tablet         capsule         liquid         inhalation     injection

\_\_\_\_\_  
How often and what times

\_\_\_\_\_  
Purpose

\_\_\_\_\_  
Side effects

\_\_\_\_\_  
Remarks

\_\_\_\_\_  
Printed name of physician

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Physician's Telephone number