Permission for Prescription Medications
Linden Hall

Parent or guardian and ***physician signature*** *required.*

Student Name ______________________ Date of Birth ______________

Parent Name ____

Current medications child takes including drug name, dosage, route, time(s) of day and if taken with food.
Are these medication(s) to be administered at school? ☐ **Yes** ☐ **No**

Medication 1: ______________________________ Taken with food? ☐ **Yes** ☐ **No**

Dosage: __________ Route: ____________ Time of Administration: ______________

Self-carry? ☐ **Yes** ☐ **No** Self-administer? ☐ **Yes** ☐ **No**

Medication 2: ______________________________ Taken with food? ☐ **Yes** ☐ **No**

Dosage: __________ Route: ____________ Time of Administration: ______________

Self-carry? ☐ **Yes** ☐ **No** Self-administer? ☐ **Yes** ☐ **No**

Medication 3 ______________________________ Taken with food? ☐ **Yes** ☐ **No**

Dosage: __________ Route: ____________ Time of Administration: ______________

Self-carry? ☐ **Yes** ☐ **No** Self-administer? ☐ **Yes** ☐ **No**

If yes, I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent authorization must be submitted.

Parent/Guardian Signature ______________________ Date ______________

Physician or Nurse Practitioner Name ______________________ Phone ______________

Physician or Nurse Practitioner Signature ______________________ Date ______________

***Signature is required for all medications unless prescribed for a short term. i.e. Amoxicillin for 10 days; pharmacy-labeled bottle will suffice.*