Prescription Medication Form

School Year ____________

To be completed by Physician/NP/PA:

Name of student____

Medication____

Instructions:

Dosage ______________________________ Time given: ______________________________

Indications (for prn drugs) ____

____

To be given: from (date) ______________ to _____________ or entire school year ____________

Significant information (include side effects, toxic reactions, omission reactions) ______________________

Contraindications for administration ____

Physician/NP/PA contact information:

Print name _________________________________ Telephone _____________________________

Prescription medication will be furnished by parent in properly labeled by a pharmacist with identifying information (name of child, medication dispensed, dosage prescribed, and the time it is to be given).

Physician/NP/PA signature _______________________________________ Date ____________________

Parent's Permission:

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed Physician/NP/PA. I hereby release The Epiphany School and their agents and employees from all liability that may result from my child taking the prescribed medication.

Parent's signature ______________________________ Date ____________ Phone # _____________