VENUS INDEPENDANT SCHOOL DISTRICT

REQUEST FOR ADMINISTRATION OF

PRESCRIPTION MEDICATION

DURING SCHOOL HOURS BY SCHOOL PERSONNEL

Name of Student_____D.O.B._____

I hereby request and give permission to the school nurse or other authorized personnel to administer the following medication to my child:

Name of Medication_____

Dosage Strength_____

Directions_____

Remarks/Comments_____

Prescribing Physicians Name_____

Physicians Phone Number_____

PERSCRIPTION MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY OR PHYSICIAN

The label should clearly list the name of the medication, dosage instructions and date perscribed.

If medication is to be given at home and at school, request the pharmacist to divide the perscription into two containers.

If any revisions the above request occur, a written revised statement must be submitted to the school. In addition, it is the students responsiblity to come to the clinic for the medication unless he/she is physically unable to do so.

Parent/Gaurdian Signiture_____ Date_____