

NORTH ALLEGHENY SCHOOL DISTRICT

Parental Medication Permission Form

Grade 9-12

All Medication Must Be In Original Container Labeled With:

1. Name of Child 2. Amount of Medication to be taken 3. Time medication is to be taken

PRESCRIPTION MEDICATION

Student's Name _____		Age _____
Grade _____	Homeroom/Team _____	Student # _____
Medication	# 1 _____	# 2 _____
Dosage	_____	_____
Time	_____	_____
# Days	_____	_____
Amount Sent	_____	_____
Side Effects	_____	_____
Reason for Medication	_____	_____
Prescribed by	<input type="checkbox"/> Physician <input type="checkbox"/> Dentist	<input type="checkbox"/> Physician <input type="checkbox"/> Dentist
Physician/ Dentist	Name _____ Phone _____	Name _____ Phone _____

LIST ALL OTHER MEDICATION YOUR CHILD IS CURRENTLY TAKING:

If your child is going on a field trip and you wish for him/her to receive this medication, you must notify the school nurse to make the necessary arrangements. The medication will be given to the staff member on the morning of the field trip and will be clearly labeled with specific instructions. The child will dispense the medication to himself/herself while a staff member observes.

I give my permission for the Certified School Nurse to contact our physician or dentist, as necessary, regarding the medication I am sending with my child.

Parent Signature:
(x) _____

Telephone - Home _____

Work _____

Cell _____

Date: _____

ONLY PRESCRIBED MEDICATION CAN LEGALLY BE ADMINISTERED BY LICENSED MEDICAL PERSONNEL

CONTINUED NEXT PAGE (MUST FILL OUT BOTH PAGES)

ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINER AND LABELED WITH:

1. Name of student
2. Dosage of medication to be given/taken
3. Time medication is to be given/taken

STUDENT NAME: _____

GRADE: _____ Age: _____ HT: _____ WT: _____

Prescription Medication: _____ Dosage: _____
Time Given/taken: _____ # Pills in container: _____
Length of treatment (i.e. Antibiotics) Start: _____ Stop: _____
Reason for Medication: _____

Prescription Medication: _____ Dosage: _____
Time Given/taken: _____ # Pills in container: _____
Length of treatment (i.e. Antibiotics) Start: _____ Stop: _____
Reason for Medication: _____

Please list any other prescribed medication student takes on a regular basis with above information included:

Physician prescribing above meds: _____ Phone # _____

Please list any over the counter drugs student takes on a regular or semi-regular basis. Include # of pills per container. Medication must be in the original container and marked with student's name.

I understand that my son/daughter will be self-medicating with the accompanying drugs listed above. I give my permission for my child to self medicate based upon his/her ability to do so. I give my permission to contact our physician as needed regarding the above medications. I have given the band nurse a complete list of all medications that are in my child's possession.

Parent
Signature: _____ Date: _____