

Montpelier public schools

PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM

TO BE FOWARDED TO THE SCHOOL NURSE

Date _____

I hereby give my permission to _____ to release information to _____
Physician's Name *School Name*

concerning medication(s) prescribed for _____
Name of Student

Signature of Parent or Guardian _____

Medication _____ Dosage _____

Directions _____

Beginning Date _____ Ending Date _____

Reason for Giving _____

Signature of Physician _____

I hereby give my permission for the above named student to take the medication as prescribed above at school.

Signature of Parent or Guardian _____

No medication will be given at school until the school receives this completed form with the prescribed medication in a **container appropriately labeled by the pharmacy or physician.**

All medicine brought into the school must be kept in the Health Office during school hours.

Date received _____ Signature of School Nurse _____