PRESCRIPTION MEDICATION FORM

Please complete this form and return with any medication you wish to have administered to your child. All medications must be stored in the nurse's office and administered under the nurse's supervision.

Student's Name: _____ Date: _____

Date of Birth:_____ Home Room Teacher: _____ Grade:_____

Medication Information
(To be completed by parent/legal guardian)

Name of medication: _____

Reason for taking: _____

Dosage:_____ Frequency/Time(s) to be administered:_____

Starting Date: _____ Ending Date:_____ Special Instructions:_____

Does medication require refrigeration? Yes No

Has the student taken this medication in the past? Yes No
(First dose must be given at home)

Potential Side Effects/Contraindications/Adverse Reactions: _____

Parent Authorization: I authorize the school nurse, and in her absence, any unlicensed school personnel who have been designated by the school, to assist my child in taking the above medication. I understand that additional parent signed authorizations will be necessary if the dosage of the medication is changed. I also authorize the school nurse to talk with my child's doctor/pharmacist should a question come up about the medication, and I agree to notify the school if my child's condition changes. I understand that medication must be registered with the school nurse or the MRBS office. I understand that OTC medication must be in the original, unopened, sealed container which is labeled with the child's name, and that it must accompany this signed form containing specific instructions as to when and why such medications may be necessary. I hereby release MRBS, it's directors, officers, school nurse, employees, and agents from any and all liability, of any nature and character, which may be alleged to arise out of or relating to assistance with the OTC medication described above, provided such is in substantial conformity with the above instructions.

Parent's Signature: _____ Date: _____

Cell Number or best way to contact you: _____

Physician's Signature for Routine Prescription Medication

I authorize that the medication listed above is prescribed for the student listed above.

Physician's Signature:_____ Date: _____