# Prescription Medication Form

**Return this form ONLY when medication is being sent**

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I request and hereby give permission to school personnel to give the prescription medication to my child named below as requested by the physician.

_____
Child's name

_____
Parent signature

_____
Telephone Number

## Physician's Statement

_____ _____
Child's name Date

In order that this school child remain in optimum health and to help maintain maximum school performance, it is necessary that the following medication be given during school hours.

_____ _____
Name of medication Dosage to be given (amount)

Form of medication: ☐ tablet ☐ capsule ☐ liquid ☐ inhalation ☐ injection

_____
How often

_____
What times

_____
Purpose

_____
Side effects

_____
Remarks

_____
Printed name of physician

_____
Physician's signature

_____
Physician's Telephone number