

Appendix A

Permission for Prescription/Non-Prescription Medicine

Physician's Administration of Prescription Medicine

The following is a physician's order for medication to be given during school hours. There is no alternative schedule by which the medication can be given.

Student Name: _____ Grade: _____

Medication	Total Daily Dosage	School Dosage Administration	School Administration Time	Begin Date	DC Date

Reason for taking the medication/s:

Possible side effects:

Student Allergies to medications in the past:

All prescription medications to be given by school personnel shall be in original containers with up to date information on the pharmacy label. I request the above medication be administered to the above student by the Orchard Farm R-V School District.

Physician Signature

Date

Phone

Parent Request for Administration of Medication

I request that the above-prescribed medication be administered to my child by the Orchard Farm School District's nurse. I understand that the nurse has the right to question any medication order he/she deems potentially inappropriate, and to verify the validity of any medication order.

I understand that over-the-counter medication does not require a physician's signature unless the amount is to be given in a higher dose than recommended by the medication label for age and/or weight. The following over-the counter medication may be administered to my son/daughter/ward as directed on the label:

___ Tylenol ___ Ibuprofen ___ Tums ___ Midol

___ Benadryl ___ Other (Specify)

Parent/Guardian Signature

Date