NELSON COUNTY SCHOOLS

Authorization to Give Prescription Medication

Medication must be in the original container with the pharmacy label as proof of the physician's prescription. Signed permission will expire at the end of the school year.

Student's Name _____ **Date of Birth** _____

This medication has been prescribed for my child by:
(Prescription only)

Primary Care Provider _____

Address _____

Phone _____

These instructions should be followed in giving my child this medicine:

Name of Medicine _____

Dosage _____

Time of day for dose _____

Possible reactions or side effects (list) _____

_____

_____

I give permission for myself/my child to receive the above medication at school and waive any liability on behalf of the school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication. My signature will give permission for exchange of verbal and written communication between the physician and the school nurse/health staff regarding my child's medical regime.

Signature of Parent or Legal Guardian _____ **Date** _____

Home phone _____

Work phone _____

Cell phone _____

Emergency contact name _____

Phone number _____