Colstrip School District #19

PERMISSION FOR **PRESCRIPTION** MEDICATION

Name of Student _____ Birthdate: _____

School _____ Grade _____

Medication _____Dosage_____ Time(s) to be taken_____

Method of Administration_____Purpose of Medication_____

If PRN, please specify the minimum length of time between doses:_____

Number of day's medication will be given at school _____

Possible Side Effects _____

Physician Signature _____ Date_____

- I request this medication to be given as ordered by the licensed health professional.
- I give Colstrip Public Schools staff permission to communicate with the medical office about this medication. I understand oral and inhaled medications may be administered by nonlicensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication is to be brought to school by a parent or guardian in the original container labeled with the medication, dosage and physician prescribing this medication.

Date _____Parent/Guardian Signature _____

Telephone Numbers:_____ (home) _____ (work) _____ (cell)

Reviewed by Registered Nurse:_____ Date:_____