

ARENDELL PARROTT ACADEMY
Request for Prescription and Over-the-Counter Medication
to be Given During School Hours
2009/2010

To be completed by physician:

Name of student _____

Medication _____

Instructions:

Dosage _____ Time to be given _____

Indications (for prn drugs) _____

To be given: from (date) _____ to _____ or entire school year _____

Significant information (include side effects, toxic reactions, omission reactions) _____

Contraindications for administration _____

Physician contact information

Print name _____ Telephone _____

Prescription medication will be furnished by parent in properly labeled by a pharmacist with identifying information (name of child, medication dispensed, dosage prescribed, and the time it is to be given).
Over-the-counter medication will be furnished by parent in its original container.

Physician's signature _____ Date _____

*** ** **

Parent's Permission:

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Arendell Parrott Academy and their agents and employees from all liability that may result from my child taking the prescribed medication.

Parent's signature _____ Phone # _____ Date _____

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(School use only)

Reviewed and approved by _____ Date _____
School nurse's signature

Medication storage location _____

Name(s) of persons to administer medication in addition to school nurse _____

