Summer Explorations
THE ELISABETH MORROW SCHOOL

Permission for Prescription Medications

Summer Explorations
*Parent or guardian and **physician signature** required*

Student name _____ Date of birth _____

Parent name _____

Current medications* child takes including drug name, dosage, route, time(s) of day and if taken with food.
Are these medication(s) to be administered at school? ▢ Yes ▢ No

Medication 1: _____ Taken with food? ▢ Yes ▢ No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? ▢ Yes ▢ No Self-administer? ▢ Yes ▢ No

Medication 2: _____ Taken with food? ▢ Yes ▢ No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? ▢ Yes ▢ No Self-administer? ▢ Yes ▢ No

Medication 3: _____ Taken with food? ▢ Yes ▢ No

Dosage: _____ Route: _____ Time of Administration: _____

Self-carry? ▢ Yes ▢ No Self-administer? ▢ Yes ▢ No

If yes, I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, I understand that a revised written physician's statement and parent authorization must be submitted.

Parent/Guardian Signature _____ Date _____

Physician or Nurse Practitioner Name _____ Phone _____

Physician or Nurse Practitioner Signature _____ Date _____

* A signature is required for all medications unless prescribed for a short-term (i.e. Amoxicillin for 10 days; pharmacy-labeled bottle with suffice.)