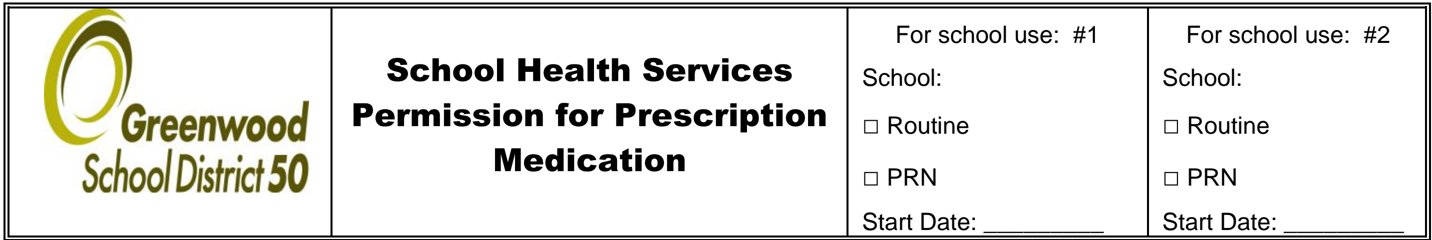
Rx **Rx**



Greenwood School District 50	**School Health Services Permission for Prescription Medication**	For school use: #1 School: ☐ Routine ☐ PRN Start Date: _________	For school use: #2 School: ☐ Routine ☐ PRN Start Date: _________

____ ______ _______________

Student's Name Grade Date of Birth

Medication:		Dosage:
Purpose of Medication:		Route:
When possible, medications should be given at home before or after school. No medication will be given at school without parent's written permission. Prescription medications also require authorization from the student's Health Care Provider. All medications must be in their original container and must be properly labeled. Students are not allowed to keep medication with them without special permission. (See district policy). Students are not allowed to take medication home from school. An adult must pick up any unused medications. Schools are not allowed to return unused medications to students. Medications not picked up by the last day of school will be destroyed.	Time of day medication to be given at school: ☐ Every morning ☐ Lunchtime ☐ Only if needed ☐ Other___________ Anticipated number of days medication needs to be given at school: ☐ until end of current school year ☐ _______ weeks ☐ _______ days Possible Side Effects:	

Prescription Medications Require Health Care Provider Authorization

Prescribing Health Care Provider's Signature: (Or provide copy of signed prescription)	Date:
Insert Provider's Name and Address Stamp Below:	Office Phone Number: Office Fax Number:

I give permission for my child, ______________________________, to take the above medication at school as prescribed. I give permission for the school nurse, principal or the principal's designee to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider or his/her employees to share information about this medication and my child's health with the school. I understand that the school has a written medication policy and by signing below, I agree to adhere to it.

❖ ***Parents must make arrangements in advance for any medications to be sent on off campus field trips.***

____ ___________________

Signature of Parent / Guardian Date

____ ___________________

Print or Type Name of Parent / Guardian Day Phone Number

Revised 06/2015