SAN JOSE EPISCOPAL DAY SCHOOL MEDICATION FORM

Parent permission for the administration of prescribed and over-the-counter medication.

DATE ____________

STUDENT_____________________________TEACHER__________________________________

NAME OF MEDICATION____

PRESCRIPTION NUMBER ________________________PRESCRIPTION DATE_______________

DOCTOR PRESCRIBING MEDICATION____

DOCTOR PRESCRIBING MEDICATION PHONE NUMBER ______________________________

START DATE ________________________DISCONTINUE DATE_______________________

AMOUNT TO BE GIVEN____________________TIME(S) TO BE GIVEN _____________________

RETURN MEDICATION HOME DAILY YES_____ NO________

REFRIGERATION REQUIRED YES_______ NO _______

SPECIFIC INSTRUCTIONS (i.e. give with water, before/after meal)__________________________
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OVER THE COUNTER MEDICINES ALLOWED:

____MOTRIN _____TYLENOL_____BENADRYL ____COUGH DROPS _____TUMS
____HYDROCORTIZONE CREAM ____BENADRYL CREAM _____ SALINE EYE WASH
____NEOSPORIN ____ [OTHER:]

I grant permission for the Principal or the Principal's designee to assist in the administration of the prescribed over-the-counter medication and/or the selected over the counter medications for the above named child. I certify that the prescribed medication is in its ORIGINAL container and that it is necessary, according to the doctor's instructions, for this medication to be provided during the school day, extended day care, or times when my child is away from school property on official school business. I understand that this medication will be given only according to the directions on the label as prescribed by the doctor, or the directions on the over-the-counter medication. Further, I agree to waive any claims of liability that may arise against any school personnel relative to the administration of medication to my child/legal ward according to these directions.

ALL MEDICATIONS MUST BE BROUGHT TO THE SCHOOL OFFICE. MEDICATIONS MAY NOT BE BROUGHT TO THE CLASSROOM.

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Signature of Parent/Legal Guardian Date