Permission to Give Medication–Long term and emergency*

Request for Medication to be Administered During School Hours

Child's name _____ Room # _____

Name of over-the-counter medicine _____

Dose _____ **Time(s) to be given** _____ **Date(s) to be given** _____

I request that my child, named above, be assisted in taking the named over-the-counter medication at school by Meher Schools staff on the days listed *or for the following circumstance:*

_____

_____

Parent's signature _____ Date _____

For prescription medicine to be administered at school, this section must be completed by a licensed physician.

Name of medicine _____ Purpose of medicine _____

Date of Prescription _____ Dosage _____ Time(s) to be given _____

Date(s) or circumstance when medicine is to be given _____

Special instructions, precautions, possible adverse effects, comments:

_____

_____

_____

The student named above, for whom this medication is prescribed is under my care.

Name of physician (printed) _____ Signature of physician _____

Address _____ Telephone _____ Date _____

*Please note: This form must be renewed each school year.