Springfield Public Schools

FAX: 217-525-3182

MEDICATION PERMISSION FORM
PRESCRIPTION AND/OR OVER-THE-COUNTER MEDICATIONS

Attention Parent/Guardian: This form must be returned to the school office (completed and signed by you and by your child's physician) in order for your child to receive medication at school.

Child's Name _____ Date of Birth _____ Grade _____

TO BE COMPLETED BY PHYSICIAN

_____ is under medical care for _____

_____

and the following medication(s) is/are required:

Name of Drug	Dosage Frequency	Time to be given at school	Duration	Side Effects

Must this medication be administered during the school day in order to allow the child to attend school?

☐ Yes ☐ No

Signature of Physician _____ Date _____

Printed Name of Physician _____

Address _____

Phone _____ Fax _____

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I hereby request that my child _____ receive from assigned school personnel the above medication(s) as directed by the physician.
The medication will be sent to school in an appropriately labeled bottle/container from the pharmacy.
I will assume the responsibility of bringing the medication or assign this responsibility to an adult designee.
I will notify the school, in writing, if the medication is discontinued.
I will obtain a written physician's order if the medication dosage is changed.
I give permission for the school nurse/building principal to contact the above physician in regard to any medication concerns.
I understand that this consent is good for the current school year only and must be completed for each succeeding school year.

Parent/Guardian _____ Date _____

Daytime Telephone _____