Springfield Public Schools

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 _____