MONTOURSVILLE AREA SCHOOL DISTRICT

PRESCRIPTION MEDICATION FORM

Date: _________________________ School Year _______- ________

Student: ____

Address: ____

Phone: (Home) ____________________________ (Work) ______________________________

MEDICATION	STRENGTH	DOSAGE	TIME TO BE GIVEN	ROUTE	DURATION OF ORDER

Purpose of Medication:

____

Side Effects:

____

Comments; ____

____
Physician's Signature and date

PARENTAL PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

I, ______________________________________, parent/guardian of __________________________________

(Name of parent/guardian) (Name of student)

Hereby authorize the **MONTOURSVILLE AREA SCHOOL DISTRICT's** school nurses to administer the above prescription medication to the above named student. The Prescription medication will be accompanied by the prescribing physician's instructions and in the **original** pharmaceutically dispensed and properly labeled container.

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Parent/Guardian Signature