Jefferson Township Public Schools

Medication Permission Form

Please complete this form in its entirety if your child is in need of **prescription** or **over-the-counter** medication in school. States law prohibits students from having medication in their possession and from administering their own medication. If the school nurse is to administer the medication, parental permission and a written statement from the physician prescribing the medication is required. This mandate applies to all topical medications as well.

*If your child is in need of an asthma inhaler and/or epinephrine auto-injector, please use the Asthma Action Plan and/or Allergy Emergency Action Plan found on the Health Services webpage of the Jefferson Township Public Schools website.

An adult must bring prescription medication to school in the pharmacy container labeled with child's name, drug name, dosage, specific time to be given and prescribing physician's name to assure the correct identification of the drug. **Over the counter medications must be brought by an adult** in its original unopened package with your child's name written on it. Thank you for your cooperation in this matter.

Parent's Request for Administration of Medication during School Hours

The nurse at _____ school has my permission to administer the following medication to my child _____ for the purpose of treating _____.

As a parent/guardian, I give my permission for the nurse to contact the physician/dentist if necessary.

Name of medication_____ Dose _____ Time to be given_____

_____ _____

Date (Signature of parent/guardian)

Physician Request for Administration of Medication at School

Name of Student _____ D.O.B._____

Name of medication_____ Dose _____ Time to be given_____

Duration _____ Reason for medication _____

Possible side effects _____

This student should take this medication on:

1. Field Trips: Yes_____ No_____
2. Delayed openings Yes_____ No_____
3. Early dismissals Yes_____ No_____

Physician's Signature _____ Date_____

Physician's Name_____

Physician's Address _____ Phone_____

(Please complete all information and use address stamp)

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