PRESCRIPTION MEDICATION PERMISSION FORM
(TO BE FORWARDED TO THE SCHOOL NURSE)

Date _____

I give my permission to Milton Elementary School Nurses to exchange information with _____ concerning medication issues for _____.
Physician's name and phone number — Name of student

I also give my permission for the medication listed below to be administered at school.

Signature of parent/guardian: _____

Medication: _____
Medication name, date and time to be administered

Reason for giving: _____
Diagnosis

Beginning date: _____ Ending date: _____

Signature of Physician: _____

No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled by the pharmacy or physician. ***Please obtain a second labeled medication bottle.*** The second bottle is for use on field trips and is required by new State of Vermont Health Guidelines. All medicine brought into the school must be kept in the Health Office during school hours.

School use only

For Short-term medication use (e.g.: eye drops, antibiotics, etc.)

Date													
Time													
Initial													

Signature	Initial	Signature	Initial
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date received: _____ Signature of School Nurse: _____