

TRENTON I.S.D.
PRESCRIPTION MEDICATION FORM

PHYSICIANS INSTRUCTIONS FOR MEDICATION AT SCHOOL

Only Medication/s that are necessary to be given at school will be given

Name of Student _____ Age: _____

Grade: _____ Date of Order: _____

Name of Medication _____

Dosage _____

Time and/or circumstances of administration at school: _____

Can a reaction be expected and if so describe: _____

What should be done? _____

How long is the treatment/medication to be continued? _____

Physician or NP Signature _____ **Phone#** _____

DATE _____

I give my permission for this treatment/medication to be given as directed above, by authorized school personal. The medication is in the **original** container labeled for my child.

By signing below I give the physician my consent to release this information to authorized school personal, a faxed copy of this form is acceptable as an original. First dose must have been administrated at home in case of allergic reaction.

Parent/Guardian Signature _____ **Phone#** _____

Date _____