Parental Request to Have Prescription Medication/Treatment

Administered in School

If it is necessary for your child to receive medication during the school day, please do the following:

- Send the medication to school with a responsible adult if you are unable to take it to school
- Send the medication in the original container properly labeled with correct name, time, dose and date
- Count the tablets (unless the number of tablets is the exact number on the

Date_____

Student's Name_____

Medication_____Dose_____Time_____

Reason for medication_____

Allergies to any medications_____

Number of tablets/liquid/MDI/nebs sent _____

I am aware that the school nurse may have the need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and I give my permission.

By signing below, I give permission for my child to be given medication at school by the school nurse and I also give permission for my child to be assisted with medication by his/her teacher while on field trips for the current school year.

PARENT/GUARDIAN Signature_____Date_____

NURSE Signature_____Date_____

CHRISTINA SCHOOL DISTRICT
Educating each student to succeed

Medication Counts

EXTRA MEDICATION BROUGHT IN OR SENT HOME

Date	Medication	(+or-)	Number	Signature

MONTHLY MEDICATION COUNTS

MONTH	DATE	COUNT	SIGNATURE
SEPT			
OCT			
NOV			
DEC			
JAN			
FEB			
MAR			
APR			
MAY			
JUNE			