

AUKAMM ELEMENTARY SCHOOL
OFFICE of the SCHOOL NURSE

MEDICATION DURING SCHOOL HOURS

Name of Student _____

Diagnosis _____

Medication _____ Dosage _____

Time _____ Route _____

Duration _____

Possible side effects _____

Precautions/Restrictions _____

Other medications take _____

Date _____

Signature of Physician

Clinic _____ Phone number _____

I hereby give my permission for _____
to take the above prescription at school as ordered. I understand that it is my responsibility to furnish
the school with this medication.

Date _____

Signature of Parent/Guardian

Parent daytime phone number #1 _____ #2 _____

NOTE: The prescription medication must be brought to school in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage and the date issued. The medication will remain at school for the duration of the prescription.