METAMORA TOWNSHIP HIGH SCHOOL

Telephone (309) 367-4151 Fax (309) 367-4351

PERMISSION FORM FOR ADMINISTRATION OF
PRESCRIPTION MEDICATION

Name (Last, First, Middle) _____

Birthdate _____ Grade _____

PHYSICIAN'S ORDER (to be completed by physician)

I hereby request and authorize MTHS personnel to give:

	Medication	Dosage	Time	Duration
1.				
2.				
3.				

Diagnosis/medical reason for medication: _____

Other medications this student is taking: _____

Other recommendations/UNUSUAL side effects: _____

Physician's Signature _____ Date _____

Print Physician's Name _____ Phone _____

Address _____

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician.
2. I release MTHS personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the school of any change in the medication.
4. I give permission for the school nurse to communicate with teachers about the action and side effects of this medication.
5. I give permission for the school nurse to consult with the above-named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication(s).

Parent/Guardian Signature _____ Date _____