ST. MARK LUTHERAN

Prescription Medication Form

I request and hereby give permission to school personnel to give the prescription medication to my child named below as requested by the physician.

_____ _____
Child's Name Date of Birth

_____ _____
Telephone Number Parent Signature

Physician's Statement

_____ _____
Child's Name Date

In order that this school child remain in optimum health and to help maintain maximum school performance, it is necessary that the following medication be given during school hours.

_____ _____
Name of Medication Dosage to be given (amount)

_____ _____
Prescription Number (School Nurse) Expiration Date (School Nurse)

Form of medication: ☐ tablet ☐ capsule ☐ liquid ☐ inhalation ☐ injection

_____ _____
How often and what times Purpose

Side effects:

_____

_____

Remarks:

_____

_____

_____ _____
Printed name of physician Physician's signature

Please return this form to the school nurse, or email to nurse@stmarkhouston.org.