PH-17/a

PHOENIXVILLE AREA SCHOOL DISTRICT
Phoenixville, Pennsylvania

PARENTAL CONSENT TO ADMINISTER MEDICATION

_____ _____ _____
Child's Name Teacher Room

Dear Parent:

If it is necessary to give your child medication of any type during school hours, the following procedure must be adhered to:

1. Complete the form below and return it to the school nurse immediately.
2. Medication as prescribed by the family physician and all over the counter medications must have a doctor's order, and be delivered **by the parent** directly to the school nurse or teacher designated by the principal.
3. Doctor's written request **and** directions on a professionally packaged medication must accompany the medication.

Please complete this form and return to school nurse.

Please give medication to _____ as
Child's name

Prescribed by Doctor _____.

Name of Medication	Dosage	Time
_____	_____	_____
_____	_____	_____

_____ _____
Date Signature of Parent

_____ _____
Date Signature of Physician

09/08sj