Schuylkill Technology Center

Student Prescription Medication Form

Physician Signature Only Required if Medication is to be administered by the School Nurse

Date_____

STUDENT NAME: _____SHOP_____

Dear Parent/Guardian:

Any student who is required to take prescribed medication must have the information below on file in the school nurse's office.

If your child is required to take prescribed medication, ***even if only administered at home***, please complete ***all*** blanks and return this form to the school immediately.

This information must be updated annually or whenever there is a change in the prescription.

Name of Medication_____

Type of medication_____

Dosage(s): _____

Time(s) of administration:_____

Reason for medication_____

Possible side effect(s)_____

In the event of an emergency related to the use of this medication the student will be transported to the closest emergency room.

_____ _____

****Physician's Signature***
(Indicating approval of the above medication. Only required for prescription medication)

Parent/Guardian's Signature
(Signature indicates approval of the above medication and provides authorization for nurse to contact physician.)

PH:_____

Fax:_____

This form OR a note signed by the physician with medication information may be faxed or sent to the School Nurse's Office at 874-3567. ***Parent signature provides authorization for nurse to contact physician.***