

http://www.campbellcountyschools.net/



Campbell County School District #1 Nursing Services

Medication Permission

Student's Name:				Photo:
Date of Birth:	Grade/Teache	Grade/Teacher:		
Medication:				
Dosage: Route:				
Purpose of Medication:				
Time medication to be given at	medication to be given at Frequency (e.g. daily): Note Special storage			requirements
school:	- 1, 7, (- 0	□None □Refriger specify):		-
Anticipated number of days medication will be given at school:		Is child allergic to any food, medicines, or other items:		
$\hfill\square$ Until the end of the current school year		□No □Yes(list allergies):		
□weeks				
□days				
Special considerations/instructions:				
Possible side effects:				
Physician's Signature Date				
***Physician signature is required if medication to be administered at school for longer than 30 days.				
PARENT CONSENT I hereby give permission for my omega my responsibility to provide this medication to school. I authorize my child's medications.	medication including	the s	ecure transport and deliv	ery of this
Parent Signature			 Date	
Complete Medication Administra	ation regulation may h	oe vie	wed on District web site:	