Mount Anthony Union High School
Nursing Office
301 Park Street
Bennington, Vermont 05201-5011
802-447-8611
802-442-1284-FAX

PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM

(To be forwarded to the school nurse)

Date: _____

Student's Name_____ Date of Birth_____

Medication: _____

Directions: _____

Beginning Date: _____ Ending Date: _____

Reason for Giving: _____

Physician Signature_____ **Date**_____

This student may carry and self-administer Epi-Pen and/or Ventolin inhaler if ordered by **THE PHYSICIAN**. This may occur only with both signatures below. This privilege may be withdrawn at the discretion of the school nurse, if student safety is compromised. The parent/guardian and physician will be notified if this occurs.

_____ _____

Physician signature **Date** **Parent/guardian signature** **Date**

I hereby give permission for the school and the prescribing physician to communicate about issues regarding this medication. This student may take the medication as prescribed during school hours.
Signature of parent/guardian_____

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No medication will be given at school until the school nurse receives this completed form with the prescribed medication in a container appropriately labeled by the pharmacy or physician.

All medications brought to school must be kept in the Nurse's Office during school hours unless otherwise indicated on this form.

Date received: _____ Signature of School Nurse_____