To Parents or Guardians:
If your child needs to take medication during the school day, this form has to be completed by your medical doctor and returned to the school nurse with the medication in the original pharmacy bottle with a prescription label on it. Please keep this form in the event that you may need it. Additional copies are available from your child's school nurse.

Sylvia Grieger, School Nurse

PALISADES SCHOOL DISTRICT
Medication Dispensing Instruction Form

Physician – please complete the following:

Name of Student _____

Medication prescribed _____

Prescribed dosage _____

Time schedule _____

Reason for medication _____

Does medication require refrigeration? _____

Precautions _____

Side-effects _____

Is child taking any other medication? _____

Name of other medication(s) _____

It is my understanding that the employees of the Palisades School District charged with the dispensing of medication may rely upon my directions as contained in this letter to dispense the medication which I have prescribed for the student listed above.

This authorization shall be valid through _____. I further certify that I am the physician who prescribed the above medication and that the student who is to receive the medication is under my care.

Signature of physician _____

Printed name of physician: _____

Phone number of physician: _____

Emergency number of physician: _____

Address of physician: _____

Date: _____

_____ _____

Signature of Parent or Guardian Date