DEPARTMENT OF DEFENSE
DEPENDENT SCHOOLS
SCHOOL HEALTH OFFICE

PERMISSION FOR MEDICATION

Erlaubnis fur Medikamentengabe

To be completed by Physician

Name of Student(Des Schulers/der Schulerin)**: _____**

Name of Teacher: _____

Diagnosis and or Indication for Medication Administration: _____

Name of Medication (Medikament) **: _____Dosage (**Dosierung)**: _____**

Time (Tages zeit/ender Medikamentenausgabe)**: _____ Route: _____**

Duration of Treatment (Dauer der Behandlung)**: _____**

Possible Side Effects (Moglishe Nebenwirkungen)**: _____**

Precautions/Restrictions: _____

Other Medications taken (Werden andere Medikamente genommen?)**: _____**

_____ _____

Date (Datum) **Physician's Signature** (unterschrift des behandelnden Arztez)

Phone Number (Telefon nummer des Hausarztes): _____

To be completed by Parent.

I hereby give my permission for _____to receive, from the School Nurse and or other trained school personnel, the above-prescribed medication/s. I understand it is my responsibility to furnish this medication to the school. I give permission for Patch Elementary School Nurse and Health Care Providers at the Medical Treatment Facility to exchange information about my child, the diagnosis for which this medication is prescribed and my child's response to the medication.

_____ _____

Date **Parent's Signature**

Parent daytime phone Number #1 _____ #2 Cell _____

Parent E-Mail Address _____

NOTE: *The prescription medication MUST be brought to school in its original container, appropriately labeled by the pharmacy or physician, stating the name of the child, the name of the medication, the dosage, and the date issued. The medication WILL remain at the school for the duration of the prescription. This medication must be brought to the school officials by the parent.*