Department of Defense Education Activity

Camp Lejeune Dependents Schools

To be completed by physician

Name of Student:_____

Diagnosis/Indication for Medication Administration: _____

Medication:_____ **Dosage:**_____

Time: _____ **Route:** _____

Duration:_____

Possible Side Effects:_____

Precautions/Restrictions:_____

Other Medications Taken:_____

_____ _____

Signature of Physician **Date**

Clinic: _____ **Phone:** _____

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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 prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication. I give permission for the 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.

_____ _____

Signature of Parent/Guardian **Date**

Parent daytime phone number #1_____, #2_____,

#3 _____

Parent e-mail address _____

NOTE: ***The prescription medication must be brought to school by an adult in the original container (labeled by the pharmacy or physician) stating the name of the student, the medication, the dosage, and current date. The medication will remain at school for the duration of the prescription.***

(School Use Only) *Reviewed on _____ by _____ (School Nurse)*