TRENTON ISD
PRESCRIPTION MEDICATION FORM

PHYSICIANS INSTRUCTIONS FOR PRESCRIPTION MEDICATION AT SCHOOL

Only medications that are necessary to be given at school will be given

Name of Student _____ DOB_____

Age: _____ Grade: _____ Date of Order: _____

Name of Medication_____

Dosage & Route _____

Time and/or circumstances of administration at school: _____

_____

Length medication to be continued: _____

Can a reaction be expected and if so describe: _____

_____

What should be done: _____

Physician name: _____

Physician or NP Signature _____

Phone# _____ Fax #_____

DATE_____

I give my permission for this treatment/medication to be given as directed above, by authorized school personal. The medication is in the **original** container labeled for my child.
By signing below I give the physician my consent to release this information to authorized school personnel, a faxed copy of this form is acceptable as an original. First dose must have been administrated at home in case of allergic reaction.

Parent/Guardian Signature _____Date_____

Phone# _____