# MOUNTAIN POINTE HIGH SCHOOL
# MEDICATION PERMISSION SLIP
# SCHOOL YEAR _____

**PARENT'S CONSENT FOR GIVING MEDICATION AT SCHOOL**

**I hereby request and give my consent for the school nurse or person designated by the administrator to see that my child,**

_____

**receives the medication prescribed by** _____

**for the period from** _____ **to** _____

**The medication is to be furnished by me in the original container and is to be labeled with and given in the following manner:**

1. **Name of medicine and prescription number** _____
2. **Route of administration (by mouth, etc.)** _____
3. **Amount to be given** _____
4. **Time of day to be taken** _____
5. **Expected duration of treatment** _____
6. **Physician's name (Must be on the label)** _____
7. **Reason for medication** _____

_____ _____

**Signature (Parent/Guardian)** **Date**

******* (Initials)_____I understand that it is my student's responsibility to report to the Health Office at the appropriate time for medication administration.**

******* (Initials)_____I understand that it is my responsibility to pick up any of my student's unused medication by the last day of the school year, or it will be disposed of. I also understand that I will not receive a reminder notification or telephone call to pick it up.**

_____ _____

**Signature (Prescribing Physician)** **Date**

**Comments by school nurse:**

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**THE SCHOOL MUST BE NOTIFIED IMMEDIATELY OF ANY CHANGE IN MEDICATION.**