PH-17a

PHOENIXVILLE AREA SCHOOL DISTRICT
Phoenixville, Pennsylvania

PARENTAL CONSENT TO ADMINISTER MEDICATION

_____ _____ _____

Child's Name Teacher Room

Dear Parent:

If it is necessary to give your child medication during school hours, the following procedure must be adhered to:

1. Complete the form below and return it to the school nurse immediately.
2. Medication as prescribed by the family physician must be delivered by the parent directly to the school nurse or teacher designated by the principal.
3. Doctor's written request and directions on a professionally packaged medication must accompany the medication.

Please complete this form and return to school nurse.

Please give medication to _____as

prescribed by Doctor_____.

Name of Medication	Dosage	Time
_____	_____	_____
_____	_____	_____

_____ _____

Date Signature of Parent or Guardian