



St. Wenceslaus School
15353 Pacific Street, Omaha, NE 68154

SCHOOL MEDICATION PERMISSION FORM
FOR: PRESCRIPTION MEDICATIONS & OVER THE COUNTER MEDICATIONS

Student's Name _____ Age _____

Teacher _____ Grade _____

IMPORTANT INFORMATION: St. Wenceslaus School regulations require that a parent bring the child's medication to the school office for proper handling and logging into the nurse's office. This procedure assures that the staff and the parent are aware the medication is to be given during school hours and that the medication has not left an adult's supervision. This regulation is to protect your child.

SHORT TERM AND LONG TERM PRESCRIPTION MEDICATION

I hereby grant permission for appropriate personnel of St. Wenceslaus School to supervise the administration of the below named **physician prescribed medication** for my child. I understand the medication will be **given only for the dates noted below** and that I am accountable to provide the medication

- in a prescription bottle,
- labeled with my child's name, the drug name and the dosage and date of expiration.

Your pharmacy can provide an empty extra-labeled bottle upon request.

Parent signature (required) _____

Medical condition to be treated _____

Signature of Physician (required) _____ **Date** _____

Printed name of physician _____

Medication name _____

Dosage _____ Administration time _____

Starting Date ____/____/____ Ending Date ____/____/____

SHORT TERM OVER THE COUNTER MEDICATION

Medication is given for 3 school days per episode & only with parent/guardian signature.

Medication _____

Reason for medication _____

Dosage _____ Time to give ____:____ am / pm (circle please)

Start date ____/____/____ End date ____/____/____

PARENT SIGNATURE _____ **Date** ____/____/____