

**OMAHA PUBLIC SCHOOLS
PERMISSION FOR MEDICATION
HEALTH SERVICES**

Dear Parent or Guardian:

We attempt to discourage the administration of medication in the schools. However, if your physician decides it is necessary for your child to receive a medication during the school day, the approval and specific directions for administration must be provided. (This includes all over-the-counter medications including tylenol, cough drops, cough syrup, etc.) It is recommended the first dose of the medication be administered at home.

Send the medication to school in the original container with the current prescription label attached. Upon request, your pharmacist may label two containers, one for home and one for school.

Please take this form to your physician and have the instructions for administration recorded. Also, please sign your authorization for school personnel to administer the medication. Thank you.

_____ School Nurse _____ School _____ Phone

I hereby authorize school personnel to administer the medication listed below to my child.

_____ during school hours.
Child's Name

_____ Parent of Guardian Signature _____ Date

I give permission for my child, _____, to bring his/her medication(s) home at the end of the school year.

_____ Parent or Guardian Signature _____ Date

PHYSICIAN'S INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

Name of Student: _____ Date of Order: ____/____/____

Diagnosis: _____

Name of Medication: _____

Dose: _____

Time and Circumstance of Administration at School: _____

Can a Reaction be Expected? _____ If so, please describe _____

_____ Physician's Signature (_____)
Phone