



UPPER SCHOOL PERMISSION FOR MEDICATION

Complete only if your student requires a medication – other than Acetaminophen, Ibuprofen, Pepto Bismol and Benadryl. A physician's signature is required for all medication other than the above listed OTC medications. Do not send any medication without this completed permission form. Responsible students may carry asthma inhaler. Please complete permission form with signatures.

Name of Student _____ Grade _____
Medication to be given _____
Dosage _____
Purpose of medication _____
Time of day medication is to be given _____
Possible side effects _____
Anticipated number of days medication is to be given _____
Will medication need refrigeration? _____

SELF-ADMINISTRATION – ONLY FOR OFF-CAMPUS EXCURSIONS

With the authorization of a parent and physician, an US student may self-administer the above noted medication on off-campus trips. **Send only the amount of medication necessary for the duration of the trip.** All medications must be in the original pharmacy bottle. **With this authorization the student is solely responsible for administration of medication – no teacher will remind the student about his or her medication.**

As the parent/guardian of _____ (student name), I give my permission for him/her to carry and self-administer the above named medication when on a school sponsored excursion. As the parent/guardian, I accept responsibility for any misuse of this medication. I have discussed this procedure with my student.

Signature of Parent: _____ Date: _____

***Signature of Physician:** _____ Date _____

NURSE/ FACULTY ADMINISTRATION

I give my permission for the nurse or, a CSS faculty member to administer the above medication as ordered. All medication should be delivered to the Nurse. If medication will be taken off-campus, nurse will deliver medication to faculty member. It is the parent's responsibility to provide this medication in the originally labeled pharmacy container. Send only the amount of medication necessary for the duration of the trip.

Signature of Parent _____ Date _____ Phone _____

***Signature of Physician.** _____ Date _____ Phone _____