PH-17/a

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
child's name

prescribed by Doctor ____.

Name of Medication	Dosage	Time
____________________________	_____________	___________
____________________________	_____________	___________

________________________ ____
Date Signature of Parent

________________________ ____
Date Signature of Physician

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