The Madeira School
Permission for Prescription & Over-the-Counter Medications

This form must accompany all medication

Parent signature required for all medications. Physician signature required for all prescription medication.*

Student Name: _____ **Date of Birth:** _____

Parent Name: _____

Medication Name: _____

Prescribed Dosage: _____ Medication Strength: _____

Frequency/Time of Administration: □ Morning □ Noon □ Evening □ Bedtime

□ Other: _____

Start Date: _____ End date (If Applicable): _____

Medication Name: _____

Prescribed Dosage: _____ Medication Strength: _____

Frequency/Time of Administration: □ Morning □ Noon □ Evening □ Bedtime

□ Other: _____

Start Date: _____ End date (If Applicable): _____

Discontinued Medication Name:

Prescribed Dosage: _____ Medication Strength:_____

Frequency/Time of Administration: □ Morning □ Noon □ Evening □ Bedtime

End date:

Special Instructions:

I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. ***Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent authorization must be submitted.***

Parent Signature: _____ Date: _____

Physician Name: _____ Phone/Email: _____

Physician Signature: _____ Date: _____