

SCHUYLKILLVALLEY SCHOOL DISTRICT

Leesport, PA 19533

Health Services
Medication Permission Form

Dear Parent/Guardian:

In order to comply with your request that we administer medication to your child during school hours and to prevent a possible error in giving medication, this permission and information form must be completed and returned to the school nurse. This applies to both prescription medication and over the counter medications, such as cough drops and cough syrup. The medication must be in the original pharmaceutical container and must be properly labeled.

Any changes in type or dosage of medication must be reported to the nurse. Do not send unlabeled bottles to school. Information on the label must include what is listed below.

Kathy Reedy, BSN, M.Ed., RN, CSN
Amy Strayer-Gray, RN, BSN, CSN
Elaine Balthaser, RN

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I give my permission for the school nurse, or her designee, to give the following medication to my child during school hours.

Name of student _____ Grade _____

Name of medication _____

Dosage (amount to be given) _____

Time and dates to be given _____

Physician's signature _____