

*Immaculate Heart of Mary School
1000 Shipley Road
Wilmington, DE 19803
302-764-0977*

PERMISSION TO TAKE PRESCRIPTION MEDICATION AT SCHOOL

Date _____

Grade/Homeroom _____

My son/daughter _____ has my permission to take
(Name of student)

_____ in _____
(Name of medication) (dosage)

(amount to be taken), at the following time _____ for _____
(diagnosis)

I accept full responsibility for his/her actions. I understand the medication will be kept in a safe place and my son/daughter is to administer the above stated medication to himself/herself under the supervision of an adult. I have provided the above named medication in a container marked with my child's name, the name of the medication, plus the dosage and schedule.

(Signature)

I give permission for this medication to be given to my son/daughter on Field Trip days, by the teacher, teacher's aide or other specified person.

(Signature)

List any allergies or health problems your child has: _____

Please complete, sign and return this form to school. Medication will not be given without this completed and signed form. Please contact the School Nurse if you have any questions at 302 764-0977 ext. 122.