

**Cedar Bluffs Public Schools**

**Prescription Medication  
Parental Permission and Instruction Form**

Date: \_\_\_\_\_ Student's School: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardians: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Numbers: \_\_\_\_\_

Cell Phone Numbers: \_\_\_\_\_

*Please Note: The first dose of a new prescription should be given at home by parent/guardian to observe for any adverse reaction.*

Doctor: \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_

Rx #: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

**Name of Medication** including instructions for administration: (For example:  
Amoxicillin 250 mg. One by mouth three times per day. Please give at school at 2:00.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Start date: \_\_\_\_\_ Completion date: \_\_\_\_\_

Possible adverse effects: \_\_\_\_\_  
\_\_\_\_\_

I/we, as parent/guardian of above named student, request that the designated providers dispense the above named medication to my child as per the instructions on this form and/or on the prescription. I certify that the medication provided is the medication on the Rx. I/we understand that monitoring the effects and possible adverse reactions of this medication remains our responsibility and therefore release the above named school and its' employees from all liability relating to the dispensation of these medications to our child. I/we give permission to share medical information/treatment plan with appropriate school personnel. I/we give permission for appropriate school personnel to contact either the medical prescriber and/or the pharmacy if necessary.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

[7-9-01 L. Hardy, R.N.]