



**DEPARTMENT OF DEFENSE
DEPENDENT SCHOOLS
PATCH ELEMENTARY SCHOOL
SCHOOL HEALTH OFFICE**



**PERMISSION FOR MEDICATION
Erlaubnis für Medikamentengabe**

To be completed by Physician

Name of Student(Des Schulers/der Schulerin): _____

Name of Teacher: _____

Diagnosis and or Indication for Medication Administration: _____

Name of Medication (Medikament) : _____ **Dosage** (Dosierung): _____

Time (Tages zeit/ender Medikamentenausgabe): _____ **Route:** _____

Duration of Treatment (Dauer der Behandlung): _____

Possible Side Effects (Mogliche Nebenwirkungen): _____

Precautions/Restrictions: _____

Other Medications taken (Werden andere Medikamente genommen?): _____

Date (Datum)

Physician's Signature (unterschrift des behandelnden Arztes)

Phone Number (Telefon nummer des Hausarztes): _____

To be completed by Parent.

I hereby give my permission for _____ to receive, from the School Nurse and or other trained school personnel, the above-prescribed medication/s. I understand it is my responsibility to furnish this medication to the school. I give permission for Patch Elementary School Nurse and Health Care Providers at the Medical Treatment Facility to exchange information about my child, the diagnosis for which this medication is prescribed and my child's response to the medication.

Date

Parent's Signature

Parent daytime phone Number #1 _____ #2 Cell _____

Parent E-Mail Address _____

NOTE: The prescription medication *MUST* be brought to school in its original container, appropriately labeled by the pharmacy or physician, stating the name of the child, the name of the medication, the dosage, and the date issued. The medication *WILL* remain at the school for the duration of the prescription. This medication must be brought to the school officials by the parent.