FORSYTH PUBLIC SCHOOL
"The Dogies"
School District No. 4 and Forsyth High School District
PO Box 319
Forsyth, MT 59327
406-346-2796

Prescription Medication Administered at School

Student Name:_____ Grade:_____ School Year:_____

Student Address:_____

TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER:

Name of Medication:_____

Dose:_____ Time to be given:_____ (during school hours)

Form of medication:_____Tablet _____Liquid ____Other

Reason for medication to be administered:_____

Start Date:_____ End Date:_____

Special Instructions:_____

Physician/HealthcareSignature:_____ Date:_____
Physician/Healthcare Provider Information:
Name:_____

Phone:_____ Fax:_____

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy. I agree and am responsible to:

- **Deliver this medicine to school in its original container.**
- **Tell the school as soon as possible if there is a change in the use of this medicine.**
- **Tell the school if my child gets a new healthcare provider.**
- **Complete a new medicine form for this medicine if there are dose changes.**

I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature:_____ Date:_____

Parent/ Guardian Phone:_____

******THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR*****