Wa-Nee Community Schools

LONG – TERM MEDICATION FORM

The Wa-Nee Community School Corporation requires students who need to take medication for longer than a two-week period to provide the school with a permission form signed by both the physician and the parent/guardian.

NAME OF STUDENT: _____ GRADE: _____

DATE OF BIRTH: _____ SCHOOL: _____

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TO BE COMPLETED BY PHYSICIAN

NAME OF MEDICATION: _____

DOSAGE: _____

TIME OR FREQUENCY: _____

SPECIAL INSTRUCTIONS: _____

_____ _____

DATE PHYSICIAN'S SIGNATURE

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TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child _____ to receive the above medication as directed by our physician. I also give the school and physician permission to communicate and release information to each other as needed.

_____ _____

DATE PARENT/GUARDIAN'S SIGNATURE