

CWS Medication Permission Form

OFFICE USE ONLY

Received Medication and Dosage Received From

OVER THE COUNTER MEDICATION REQUEST

Fill out this section if your child needs non-prescription medication for less than 10 days.

Student _____ DOB _____

Name of Medication _____

Specific time(s) and dose(s) to be given at school: _____

Length of time to be given _____

I, _____,
the parent/legal custodian of _____
request that a member of the CWS administration administer the
above medication to *(child's name)* _____
during school hours and at the times indicated. I agree to furnish
said medication in the **ORIGINAL** container supplied by the
pharmacy with the label intact. I understand and accept that the
CWS Board of Trustees, its employees, agents, or designees are
not responsible for any effects of the medication administered.
Any nonprescription medication that is to be given for more than
a week must be authorized in writing by a physician.

Date _____

Signature of Parent/Legal Custodian

TO BE COMPLETED BY PHYSICIAN

Fill out this section if over-the counter medication will be needed for more than a week OR if prescription medication needs to be taken at school

I certify that, in my opinion, it is medically necessary that
the medication described below be administered to *(child's name)*
_____ during school hours and that this medication
may be administered by school personnel.

Prescription:

Medication _____

Dosage and Time _____

Duration _____

Date of Prescription _____

Diagnosis requiring medication _____

Date _____

Signature of Physician

TO BE COMPLETED BY PARENT/LEGAL CUSTODIAN

I, _____, parent or legal
custodian of _____, request that a
member of CWS administration administer the above medication
to _____ during the school
hours and at the times indicated. I agree to furnish said
medication in the **ORIGINAL** container supplied by the
pharmacy with the label intact. I understand and accept that the
CWS Board of Trustees, its employees, agents, or designees are
not responsible for any effects of the medication administered.
Any nonprescription medication that is to be given for more than
a week must be authorized in writing by a physician.

Date _____

Signature of Parent/Legal Custodian

Home Telephone Number

Work Telephone Number

**NOTE: PLEASE RETURN THIS FORM WITH
MEDICATION OR HAVE YOUR PHYSICIAN FAX IT
TO CWS AT 434-973-4109**