



BRANDYWINE SCHOOL DISTRICT

1311 Brandywine Boulevard
Wilmington, DE 19809-2306

(302) 793-5000
www.brandywineschools.org

MARK A. HOLODICK, Ed.D.
Superintendent

RALPH ACKERMAN
President, Board of Education

**Parental Request/Permission to Have Medication
Administered in School**

If it is necessary for your child to receive medication during the school day, please do the following:

- Send the medication to school with a responsible individual if you are unable to take it to school.
- Send the medication in the original container. If a prescription, the container must be properly labeled with correct name, time, dose, date, and prescribing licensed healthcare provider.
- Count the tablets (unless the number of tablets is the exact number on the label) or approximate amount of liquid in the bottle.
- Pick up the medication from school at the end of the school year.

Date _____

Student's Name _____

Medication _____

Dose _____ Time _____

Reason for Medication _____

Allergies to any medications _____

Number of tablets sent _____

Amount of liquid _____

I am aware that the school nurse may need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and that he/she is required to use nursing judgment regarding all medication administration. I give my permission for medication administration by the school nurse

Parent/Guardian Signature _____

Nurse's Signature _____

Number of tablets/amount of liquid received:(record and initial on back)

Medication Count. This sheet should be used for monthly reconciliation and periodic counts/additions/subtractions. Please indicate by month and date if the count is the monthly count.

Student Name:

Birthdate:

Date	Medication & Dosage	Number of pills to be taken	Current count	Additions or subtractions (comment needed)	Comment	Initials