C. Parent Request for Medication to be given during school Hours
(Parent, please complete and return form to the Main Office at your child's school)

I hereby give permission for my child, _____ to receive medication during school hours. As the parent/guardian, I assume the responsibility of any adverse reactions this medicine may cause for my child. I agree to bring the prescribed medicine in a container properly labeled by a pharmacist. Nonprescription medicine will be brought in a sealed, original container.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Home telephone number Work telephone number

_____ _____

Emergency Contact Emergency telephone number

I give permission for the school to fax this Medication Record to my child's health care provider (if needed). I give permission for my child's health care provider to fax this form back to the school. I understand the school cannot guarantee the confidentiality of the fax machine.

_____ _____

Signature of parent or guardian Date

D. Medication Check-In/Check Out Log

Date	Medication/Dose	Amount Received	Received by (Signature)	Signature of Witness

E. Medication Disposal/Destroyed Log (If not picked up)

Date	Medication	Amount	Signature of RN	Signature of Witness