BRITTEN SCHOOL
AUGUST 2026- AUGUST 2027

PRESCRIPTION MEDICATION DATA AND INFORMATION PERMISSION FORM

Student's Name_____ **Date of Birth**_____

Please list on this form **every prescribed medication taken by your student at home or school** to allow us to provide comprehensive medical treatment:

Name of Medication:	Dosage:	Time Taken:	Home	School
1._____	_____mg	_____ AM/PM		
_____	_____mg	_____ AM/PM		
_____	_____mg	_____ AM/PM		
2._____	_____mg	_____ AM/PM		
_____	_____mg	_____ AM/PM		
_____	_____mg	_____ AM/PM		
3._____	_____mg	_____ AM/PM		
_____	_____mg	_____ AM/PM		
_____	_____mg	_____ AM/PM		
4._____	_____mg	_____ AM/PM		
_____	_____mg	_____ AM/PM		
_____	_____mg	_____ AM/PM		

If I have indicated that my student is to receive prescribed medication at Britten School; I give permission for the administration of the prescribed medication during the school day. The prescribed medication must be dispensed from the original prescription bottle and must be replenished in a timely manner. I understand that the Britten School Nurse is administering the prescribed medication to my child in compliance with my request and the current prescription. This form must be completed in additon to the Physician Authorization Medication Form before the prescribed medication administration begins. Accordingly, I hereby release Britten School and personnel from any and all liability as to injuries or ill effects of any kind that may be caused thereby.

☐ My student takes **NO** prescribed medication at home or during the school day.

☐ My student **does not** require prescribed medication administration during the school day.

I hereby give Britten School personnel permission to administer the above prescribed medication to my student.

☐ YES ☐ NO

_____ _____

Parent/Guardian Signature Date:

* Please note if any information changes (medication, dosage, and/or time of day) a new form must be completed.

rev 5/24/23