

PLEASE DO NOT WRITE ABOVE THIS LINE - FOR MAGNUS HEALTH USE ONLY



PRESCRIPTION MEDICATION FORM

This coversheet is **ONLY** for the form and student listed above
and **MUST BE RECEIVED** for processing.



DO NOT use staples or paperclips!



Please print and complete this form then
submit all pages including this coversheet via:

FAX	MAIL
<p>(877) 447-9530</p> <p>Outside of the United States? Please fax to (978) 244-8894</p>	<p>-OR-</p> <p>Magnus Health Does Not Accept Mailed Forms</p>

Washington International School

3100 Macomb Street NW • Washington, DC 20008

MS/US Nurse 202.495.7301 • PS Nurse 202.243.1709

PRESCRIPTION CONSENT FORM

Name of student _____ Grade _____

Name of Physician _____ Phone _____

Prescription Medication _____

Reason for Treatment _____

Time of administration _____


Dosage of medication to be given _____

Dates to be given _____

Possible side-effects _____

 **Signature of Parent *** _____ Date _____

Daytime phone(s) _____

 **Signature of Physician** _____ Date _____

Address of Physician _____ Phone _____

*This signature also authorizes the School Nurses to contact the Physician if need arises.

Medication must be in a container label by the Pharmacist with the following:

- Child's full name
- Name of medication
- Dosage
- Frequency of administration
- Physician's name
- Date dispensed
- Expiration date
- Medication must be collected within one week of expiration (or the end of the school year) or it will be discarded.
- Additional instructions (e.g., with meals, with juice, or water)

School or Health Office personnel will not assume any responsibility for unauthorized medication/treatment that students give to themselves.