

WAVERLY COMMUNITY SCHOOL DISTRICT # 6

201 North Miller

Waverly, Illinois 62692

Telephone: (217) 435-8121 Fax: (217) 435-3431

**Prescription Medication Consent**

If your child requires prescription medication during school hours, please **bring in a note from your child's doctor with the order and physician signature** to have on file and sign below.

I/we, the undersigned parent/guardian of \_\_\_\_\_,  
student at Waverly School District #6, hereby request Waverly School District to  
allow said student to be given the following medication: \_\_\_\_\_  
prescribed by Dr. \_\_\_\_\_ beginning on \_\_\_\_\_ and  
continuing through \_\_\_\_\_ under the supervision of school personnel.

**The medicine is to be furnished by me, the parent/guardian of the student, and  
medication is to be in the appropriately labeled bottle with the pharmacy label.  
The label must indicate the following: Name, Medication, Dosage, Physician  
Order, and Specific Time it is to be given at school.**

I/we assume all responsibility for any mistake in furnishing an incorrect dosage.

I/we have read and understand and agree to the school's regulations concerning  
giving medication at school.

Signature \_\_\_\_\_ Date \_\_\_\_\_