

PERMISSION FORM FOR PRESCRIBED MEDICATION

Date form received by the school: _____

Student: _____ Date of Birth, or age: _____

Grade: _____ Teacher/Classroom: _____

To Be Completed by the physician or Authorized Prescriber

Reason for Medication _____

Name of Medication _____

Form of medication/treatment:

Tablet/capsule Liquid Inhaler Injection Nebulizer Other _____

Instructions (*Schedule and dose to be given at school*): _____

Start: date form received Other date: _____

Stop: end of school year Other date/duration: _____

For episodic/emergency events only

Restrictions and/or Important effects: None anticipated

Yes. Please describe. _____

Special Storage Requirements: None Refrigerate

Other: _____

This student is both capable and responsible for self-administering this medication:

No Yes – Supervised Yes – Unsupervised

Please indicate if you have provided addition information:

On the back side of this form As an attachment

Date: _____ Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

Doctor's Signature: _____

To the School: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I give permission for (*name of child*) _____ to receive the above medication at school according to standard school policy. (***Schools require parent/guardian to bring the medication in its original container.***)

Date: _____ Signature: _____ Relationship: _____

Parent/Guardian Phone #'s: Home _____ Work _____ Emergency _____