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_____