

PERMISSION FORM FOR PRESCRIBED MEDICATION

School: _____
Date form received by school: _____
Student: _____ Date of Birth or Age: _____
Grade: _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber

Name of medication: _____
Reason of medication (OPTIONAL) _____
Form of medication/treatment:
____ Tablet/capsule ____ Liquid ____ Inhaler ____ Injection ____ Nebulizer ____ Other

Instructions (Schedule and dose to be given at school: _____
Start: _____ Date from received _____ Other dates: _____
Stop: _____ End of School year _____ Other date/duration: _____

Restrictions and/or important side 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
This student may carry this medication: ____ No ____ Yes

Please indicate if you have provided additional information:
____ On the backside of this form ____ As an attachment

Date: _____ Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

To be completed by parent/guardian

I request that (name of child) _____ receive the above Medication at school according to standard school policy.

I request that (name of child) _____ be allowed to self-Administer the above medication at school according to the school policy.

Date: _____ Signature: _____ Relationship: _____