

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

Name of medication: _____

Reason for medication: (OPTIONAL) _____

Form of medication/treatment (please circle):

Tablet/capsule

Liquid

Inhaler Injection

Nebulizer

Other _____

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

Start: ___ date form received

Other dates: _____

Stop: ___ end of school year

Other dates/duration: _____

___ For episodic/emergency events only

Restrictions and/or important side effects: ___ None anticipated ___ Yes (describe below)

Description: _____

Special storage requirements: ___ None ___ Refrigerate ___ Other (see below)

Storage requirements: _____

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

___ No

___ Yes - Supervised

___ Yes - Unsupervised

This student may carry this medication: ___ Yes ___ No

Please indicate if you have provided additional information:

___ On the back side of this form

___ As an attachment

Date: _____ Physician's 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: _____ Parent Signature: _____