PERMISSION FORM FOR MEDICATIONS TAKEN DURING THE SCHOOL DAY

SCHOOL NAME & ADDRESS _____

_____

_____

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): _____

Medication/Treatment Form: O Tablet/Capsule O Liquid O Inhaler O Injection O Nebulizer Other _____

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

START O Date form received Other dates: _____

STOP O End of School Year Other date/duration: _____

O For episodic/emergency events only

Restrictions and/or important side effects: O None anticipated

O Yes, please describe: _____

_____

Special Storage Requirements: O None O Refrigerate O Other _____

_____

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

O No O Yes, supervised O Yes, Unsupervised

This student may carry this medication: O No O Yes

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

Date: _____

Physician's Name: _____

Physician's Address: _____

Physician's Phone Number: _____

TO BE COMPLETED BY PARENT OR GUARDIAN: I request that (name) _____

O Receive the above medication at school according to standard policy.

O Be allowed to self-administer above medication at school according to standard policy.

Date: _____ Signature: _____ Relationship: _____