𐓍𐒰𐓄𐓂𐓆𐒼𐒰 𐒲𐒼𐓂𐓍𐒰𐓄𐒻

PERMISSION TO ADMINISTER MEDICATION

Student Name:		Age:	Date of birth:	Classroom:
Street Address:		City:	State:	Zip Code:
Resides with:		Emergency Contact:		Phone:
Mother's Name:	Work or cell no.:	Father's Name:		Work or cell no.:

______ I request that my student receive the following medication at school according to policy.

______________________________ ______________________ ______________________
Parent/Guardian Signature Relationship Date

____
Name of medication

Form of medication/treatment: _____ Tablet/Capsule _____ Inhaler _____ Injection
_____ Nebulizer _____ Other ______________________________

TO BE FILLED OUT BY PHYSICIAN

Instruction for administering at school: ____
____
____

Date to begin: ___________________ Date to end: _____________________

Other date/duration: ____

Restrictions/side effects: ____

______ For episodic/emergency events only

____________________________________ ________________________
Physician/Authorized Prescriber Signature Date

____________________________________ ________________________
Please print name Phone