

Permission Form for Prescribed Medication

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

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 Other date/duration: _____
 For episodic/emergency events only

Restrictions and/or important side effects: None anticipated Yes (*see below*)

If 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 back of this form As an attachment

Date: _____ Physician Signature: _____

Physician's Name:
Address:
Phone Number:

To be completed by Parent/Guardian:

I give permission for my child _____ to receive the above medication at school according to school policy. (*Medication must be in its original container.*)

Date: _____ Signature: _____

Relationship: _____