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: _____