PERMISSION FORM FOR PRESCRIBED MEDICATION

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School:____

Date form received by the
School:____

Student:____

Grade:____________

Teacher/Classroom:_________________________________

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 year Other

date/duration:__________________

______________For episodic/emergency events only

Restrictions and/or important side effects: _____None anticipated

_____ Yes. Please describe:____

____

Special storage requirements: _____ None _____ Refrigerate

Other:____

This student may carry this medication: _____No _____Yes

Please indicate if you have provided additional information:

_____On the back side of this form _____As an attachment

Date:_________________

Signature:____

Physician's Name:____

Address:____

Phone Number:____

To the school: Please report concerns about medications or disease to the school nurse.

To be completed by parent/guardian

I give permission for (name of child)____ to receive the above medication at school according to standard school policy.
(Schools require parent/guardian to bring medication in its original container.)

Date:______________ Signature:_______________________________________

Relationship:_______________