Permission Form for Prescribed or Over-the-Counter Medication

School _____ **Date form received by the School:** _____

Student's Name: _____ **Grade:** _____ **Homeroom/Classroom:**_____

Student's Age:____ **Date of Birth:** _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of medication: _____ Reason for medication: _____

☐ Prescription medication ☐ Over-the-counter medication provided by parent/guardian

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐Other

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration:_____

Restrictions and/or important effects: ☐ Yes Please describe:_____

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, she/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Student is capable of/responsible for self-administering this medication: ☐ No ☐ Yes ☐ Supervised ☐ Unsupervised

Student must carry this medication on his/her person: ☐ No ☐ Yes

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

_____ _____

Physician/Authorized Prescriber's Signature ***Date***

_____ _____

Signature of Parent/Guardian for Over-the Counter Medication ***Date***

Physician's Name: _____ **Address:**_____

Phone #:_____**Fax #:**_____

To the school: Please report concerns about medications or the student's condition to the above physician.

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for _____ to receive the above medication at school according to
Student's Name
standard school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed.

Date: _____ ***Signature:***_____ ***Relationship:*** _____

Home Phone: _____ ***Work Phone:*** _____ ***Emergency Phone:*** _____

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing Physician's Statement and Parent's Authorization.

Administrator/designee_____ **Date** _____

Review/Revised- 6/28/99