PERMISSION FORM FOR MEDICATION

School:

Date form received by the school:_____
Student:_____Date of birth, or age: _____
Grade:_____Teacher/Classroom:_____

To be completed by the physician or authorized prescriber
Reason for medication: _____
Name of medication: _____

Form of medication/treatment:
□ Table/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 effects: □ None anticipated
□ 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 side of this form □ As an attachment
Date: _____ Signature:_____

Physician's Name: _____
Address: _____
Phone Number:_____
Doctor's Signature:_____

To the school: Please report concerns about medications or disease to the above physician.
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 the medication in its original container.)*

I understand that the school shall incur no liability and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the administration of medications and/or self-administration of asthma medications.

Date:_____ Signature:_____ Relationship:_____
Parent/Guardian Phone Numbers: Home: _____Work: _____
Emergency _____Other _____