Permission Form for Prescribed or Over-the –Counter Medications

School: _____ Date received by the School_____

Student's Name: _____ Grade: _____ Teacher_____

Student's age: _____ Date of Birth_____

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 __Ointments __ Other: _____

Describe schedule and dose to be given at school: _____

Starting date: _____

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

Restriction 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, s/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 must carry this medication on his/her person __ Yes __ NO

Please indicate additional information: __On the back of this form __ as an attachment

Physician's Name:_____ Address_____
Phone# _____ Fax#_____

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

I give permission for_____ to receive the above medication at school
Student's name
according to standard school policy and expressly waive any liability on behalf of the school or it's employees and agents 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_____

_____ _____
Signature of Site Administrator/designee Date