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

Student has been instructed in self-administering the medication: ☐No ☐Yes

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 hold harmless and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication, in the proper container, 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:7/25/05