



**PERMISSION FORM FOR PRESCRIBED MEDICATION**

Date form is received by the school: \_\_\_\_\_

Name of student: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Date of birth or age of student: \_\_\_\_\_

**To be completed by the physician or authorized prescriber:**

Name of medication: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

**Form of medication/treatment:**

Tablet/capsule    Liquid    Inhaler    Injection    Nebulizer    Other \_\_\_\_\_

Instructions (Schedule and dose to be given at school): \_\_\_\_\_  
\_\_\_\_\_

**Restrictions and/or important side 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

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**To be completed by Parent/Guardian:**

I request that (name of the child) \_\_\_\_\_ receive the above medication at school according to standard school policy.

I request that (name of the child) \_\_\_\_\_ be allowed to self-administer the above medication at school according to school policy.