

PERMISSION FORM FOR PRESCRIBED MEDICATION

Child's name _____ Date of birth _____

To be completed by the physician or authorized prescriber

Name of medication _____

Reason for medication _____

Form of medication:

Tablet/capsule _____ Liquid _____ Inhaler _____ Injection _____ Nebulizer _____ Other _____

Instructions (for school dose):

Schedule/dose _____

Start date _____ End date _____

Restrictions and/or important side effects:

None anticipated _____

Yes (describe) _____

Special Storage Requirements:

None _____ Refrigerate _____ Other (please list) _____

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 _____ Date _____

Provider's stamp and/or clinic stamp

To be completed by parent/guardian

I give permission for (name of child) _____
to receive the above medication at school according to school policy.

Signature _____ Date _____