PERMISSION FORM FOR PRESCRIBED MEDICATION

Student Name: ____

School Year: 20_____/_____ Date form received by school office: ___________

Grade __________________ Teacher/Classroom__________________________

To Be Completed by Authorized Prescriber:

Name of medication: ____

Reason for use (optional): ____________________________________

Form of medication/treatment:
____Tablet/Capsule ______ Liquid ______Inhaler ______ Injection Other: ______

Dose and time(s) to be given at school: ___________________________

Start: _______ Date form received at school Other start date:_______________
Stop: _______ End of school year Other stop date:_______________

______Check if this drug is only for episodic/emergency use

Restrictions and/or Important Side Effects:
______None anticipated
______Yes, please describe: ____________________________________

Special storage needed: ____No _____Refrigerate Other: ______________

Please indicate if you have provided additional information: _____No _____On back

______________________ ___________________________ _______________
Provider Name (Print) Address Phone

______________________ ________________
Provider Signature Date

To Be Completed by Parent/Guardian:

I request that (Student) ______________________ receive the above medication at school according to school policy.

Date _______ **Signature**______________**Relationship**______________________

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