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: _____

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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