

CUMBERLAND SCHOOL DEPARTMENT

LONG TERM MEDICATION

I give permission for _____ at _____
(Name of Student) (Name of School)

DOB: ___/___/___ Grade: _____ to receive _____ as ordered below:
(Name of Medication)

Dosage to be administered: _____

Time to be administered: _____ Route: _____

Duration: From (start date): _____ to (end date): _____

Reason for medication: _____

Side effects that may occur: _____

Does the school nurse/teacher have permission to release this information to school personnel who may have a need to know (i.e. teacher, principal)? **YES NO**

Physician's signature: _____ Date: _____

Physician's Telephone #: _____ Fax: _____

Parent's Signature: _____ Date: _____

PERMISSION TO SELF-CARRY/SELF-ADMINISTER MEDICATION:

Please circle medication: INHALER EPIPEN INSULIN OTHER _____
(specify)

- I have instructed _____ in the proper use and administration of his/her medication. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.
- It is my professional opinion that _____ should not self-carry or self-administer his/her medication.

Physician's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____