APPENDIX H: MEDICATION PERMISSION FORM

PERMISSION FORM FOR PRESCRIBED MEDICATION

SAINT GABRIEL THE ARCHANGEL SCHOOL
5503 BARDSTOWN ROAD
LOUISVILLE, KY 40291
Office: (502) 239-5535 Fax: (502) 231-1464

SAINT GABRIEL CHILD CARE
5503 BARDSTOWN ROAD
LOUISVILLE, KY 40291
Office & Fax: (502) 239-1298

Student Name: _____ Date of Birth/Age: _____

Grade: _____ Homeroom Teacher: _____

To be completed by the physician or authorized prescriber:

Reason for medication: _____ Name of medication: _____

Medication Dosage:_____Time or PRN parameters: _____

Route/Form of Medication/Treatment

□ Tablet □ May crush (if applicable) □ Liquid □ Inhaler * □ Nebulizer

□ Blood sugar monitor/check □ Blood sugar guidelines: ___

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

□ Start date:_____□ End date:_____

□ For episodic/emergency events only □ Other dates/duration: ____

Restrictions and/or important effects:

□ None anticipated □ Yes. Please describe:_____

Special storage requirements:

□ None □ Refrigerate □ Other, describe: _

Please indicate if you have provided additional information:

* Inhaler release form for carrying on person More information on back of this form Other Attachments

_____ _____

Date DOCTOR'S SIGNATURE

Physician's Name (Please Print): _____ Address: _____ Phone Number: _____

Fax Number:_____

To the school: Please report concerns about medication or disease to the above physician.

To be completed by parent or guardian:

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy. (Schools require parent/guardian to bring medication in in its original container. If the dosage changes, a new form must be filled and bottle must state correct dosage.)

Signature: _____ Date: _____ Relationship: _____

Parent/Guardian Phone Numbers: _____