Office of School Support Services
STUDENT HEALTH SERVICES

SCHOOL:______________________________

PERMISSION TO CARRY MEDICATION AT SCHOOL
PHYSICIAN-PARENT-STUDENT REQUEST

Student's Name____________________________________ Birthdate____________________ Gr/Rm______________

Home Phone_____________________________Parent work/cell phone ____

DIAGNOSIS for which medication is to be given**.** (If for an allergy, please specify what type, i.e. localized, generalized, mild, severe, etc.)

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Name of medication____

Dose____

Specific time (e.g.10AM, noon, before PE, etc.)____
For PRN medications, please indicate why medication should be given (e.g., for wheeze, headache, etc)

Reactions that need to be reported to the physician____

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Medication to be continued as above until ____
(Date – no longer than the end of the school year)

PHYSICIAN'S AGREEMENT: This student's medication cannot be scheduled for other than during school hours and <u>must be carried on his/her person during the school day.</u> **The student has demonstrated a knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication.**

Physician's signature____ Date____________________________

Printed name/stamp____Phone___________________________

Address ____FAX______________________________

PARENT'S AGREEMENT: I request that my child be allowed to carry his/her medication with him/her during the school day. I have reviewed with him/her the responsibilities associated with carrying medication at school and I am aware that he/she will be subject to disciplinary action if the medication is used in a manner other than as prescribed.

Parent's signature____Date______________________

STUDENT'S AGREEMENT: I have been shown the proper way to use my medicine by my doctor and I agree to use it only in the correct and safe way that I have learned. I understand that if I use the medicine in a way that is not safe for me or others, I will lose the privilege of carrying the medicine with me.

Student's signature____ Date______________________

SCHOOL NURSE'S SIGNATURE____

COMMENTS:____