Ritenour School District
Educational Excellence Since 1867

File: JHCD-FORM-3

Title: **PARENT/PHYSICIAN PERMISSION FORM FOR PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS**

Section: Students

To be completed by parent/guardian

Student: _____ Date of Birth:_____

Grade:_____ Teacher/Classroom:_____ School Year:_____

Reason for Medication: _____

Name of Medication: _____

Form of Medication/Treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Injection

☐ Other:_____

Instructions (schedule and dose to be given at school): _____

_____

Anticipated side effects: _____

Physician's Name: _____ **Phone:**_____

Office Address:_____ **Fax:** _____

I give permission for (name of child) _____ to receive medication at school as indicated on this form. Medication provided to the school will be in its original container.

_____	_____	_____
Date	**Parent/Guardian Signature**	**Telephone**

TO BE COMPLETED BY PHYSICIAN/AUTHORIZED PRESCRIBER AFTER DOCUMENT REVIEW

Student may carry/administer his/her inhaler: ☐ Yes* ☐ No ☐ N/A

Student may carry/self-administer his/her Epinephrine Auto-Injector: ☐ Yes* ☐ No ☐ N/A

*If YES to the above, the student has been instructed in symptom recognition, self-administration and precautions involved: ☐ Yes ☐ No ☐ N/A

PHYSICIAN'S SIGNATURE: _____ **Date:** _____

03/01/22

CLINIC OFFICE USE ONLY

Date Form Received by School: _____