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

Student:_____ Date of birth:_____

Grade: _____ Teacher/Classroom:_____ Date form received by school:_____

To be completed by physician/authorized prescriber

Reason for medication: _____

Name of medication: _____

Form of medication/treatment: Tablet/Capsule _____ Liquid _____ Inhaler _____ Injection _____

Nebulizer _____ Other _____

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

_____

Anticipated side effects: _____

_____

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 self-administration and precautions involved:

Yes _____ No _____ N/A____

PHYSICIAN'S SIGNATURE: _____ Date: _____

Physician's Name: _____ Phone: _____

Office Address: _____ Fax: _____

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To be completed by parent/guardian

I give permission for (name of child) _____ to receive medication at school as indicated above. The medication is in its original container.

_____ _____ _____

Date **Parent Signature** Telephone