South Adams FAX: (260) 589-2112 PHYSICIAN NAME: _____

PERMISSION FORM FOR PRESCRIBED MEDICATION/TREATMENT

Child's Name _____ Gender _____ Birth Date _____

I request that my child be assisted in taking the medication/treatment listed below at school by authorized school personnel or permitted to medicate/treat herself/himself as authorized by me and the physician (see below).

In order to provide the best care for my child, the school nurse also has my consent to share the information below with appropriate school personnel. Yes _____ No _____

Date _____ Parent/Guardian Signature _____

THE FOLLOWING IS TO BE COMPLETED AND SIGNED BY THE PHYSICIAN:

Diagnosis for which medication/treatment is ordered _____

Name of medication/treatment _____

Dose to be given _____ Time to be administered _____

Form of medication/treatment: Tablet/capsule ____ Liquid ____ Inhaler ____

Nebulizer ____ Other (specify) _____

Date to start medication/treatment _____

Date to stop medication/treatment _____

For episodic/emergency use only? Yes ____ No ____

Restrictions and/or side effects (please describe) _____

This student is both capable and responsible for self-administering this medication/treatment:

Yes, supervised _____ Yes, unsupervised _____ No _____

If medication is an inhaler or Epi Pen, this student may carry the medication:

Yes_____ No _____

Additional comments _____

Date _____ Physician's Signature _____

Address _____ Phone_____