SCHOOL MEDICATION PERMISSION FORM

Student Name: ______________________________ DOB: ______________ Grade: ____ Teacher: ____________________

School: ________________ Address: ______________________________________ School Fax #: ____________________

TO BE COMPLETED BY HEALTH CARE PROVIDER *Please print clearly and complete **ALL** sections.*

NAME OF MEDICATION *(If medication is for asthma see the reverse side for asthma action plan. MUST be completed by the health care provider and parent.)*	**STRENGTH**	**DOSE**	**ROUTE (circle)**	**FREQUENCY (include minimum time interval for prn dosing)**	**DIAGNOSIS**	**START DATE**	**STOP DATE**
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________ OR as needed every ______ hours		__/__	__/__ OR END OF SCHOOL YEAR (circle)
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________ OR as needed every ______ hours		__/__	__/__ OR END OF SCHOOL YEAR (circle)
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________ OR as needed every ______ hours		__/__	__/__ OR END OF SCHOOL YEAR (circle)

Precautions and/or adverse reactions to report ____

Date: ________ Health Care Provider Signature: ______________________ Health Care Provider Name: ____________________

Address______________________________ Phone Number: ________________ Fax Number: ________________

TO BE COMPLETED BY PARENT OR GUARDIAN: I give my permission for (Name of child) ______________________ to receive the medications listed above at school according to standard school policy. The school nurse (or other school personnel) involved with the supervision of my child's health has my permission to exchange health information with the health care provider.

Parent/Guardian Signature: ______________________ Parent/Guardian Name: ____________________ Date: __________

Parent/Guardian Phone Numbers: Cell: ______________ Home: ______________ Work: ______________ Other: ______________

Please note: *Medication must be delivered to school by a responsible adult in the container in which it was dispensed by the prescribing health care provider, licensed pharmacist or pharmacy. If the medication or dosage is changed, a new form must be completed.* ***THIS FORM MUST BE COMPLETED EVERY SCHOOL YEAR.***

TO BE COMPLETED BY SCHOOL: Date received at school: ______________ School Nurse Signature: ________________________

ASTHMA ACTION PLAN

Student Name____ **Homeroom Teacher**_____________________________

TO BE COMPLETED BY PHYSICIAN

Please circle student's known asthma triggers: **pollens** **stress/anxiety** **cold air** **exercise**

allergy (please specify)____________________________________ **other trigger(s)**______________________________

Current medications for asthma control:____

____

Asthma medication to be given at camp:____

____

Is student capable and responsible for self-administering this medication? **Yes** **No**

May student carry inhaler? **Yes** **No**

Note: A school district may choose to follow more restrictive procedures regarding student's self-administration.

If an asthma attack occurs, follow these steps:

1. ____
2. ____
3. ____
4. ____

Other special instructions: ____

Date: ________________**Physician's Signature:**____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that:

- if symptoms are not relieved by steps taken above and indicate the need for emergency care, school personnel will activate the 911 emergency system.
- if my child self-administers asthma medication in locations other than in the presence of the camp nurse, it is my responsibility to review with my child when he/she should seek medical assistance.
- if I am not available at numbers listed on reverse side, contact:

Name____ **Phone Number**_____________________________________

Additional Comments:____

____

Parent/Guardian Signature____**Date**________________________

TO BE COMPLETED BY SCHOOL

Date received at school/camp______________________ **Nurse Signature**___________________________________