Permission Form for Prescribed or Over-the-Counter Medication

School: _____Date form received by the School: _____

Student's Name: _____ Grade: _____ Homeroom/Classroom: _____

Student's Age: _____ Date of Birth: _____

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION AND NON-PRESCRIPTION (OVER-THE-COUNTER "OTC") MEDICATION

Name of medication: _____ Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: _____

Restrictions and/or important effects: ☐ Yes. Please describe: _____

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Student is capable of/responsible for self-administering this medication: ☐No ☐Yes ☐Supervised ☐Unsupervised

Student has been instructed in self-administering the medication: ☐No ☐Yes

Student must carry this medication on his/her person: ☐No ☐Yes

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

_____ _____

Physician/Health Care Provider Signature ***Date***

_____ _____

Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____ Fax #: _____

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

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FOR ALL MEDICATIONS

I give permission for _____ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee _____ Date _____

For student health services/procedures not involving medication only,
please refer to 09.22 AP.22.