

Permission Form for Prescribed or Over-the-Counter Medication

Student's Name: _____ Grade: _____ Homeroom/Classroom: _____
 Student's Age: _____ Date of Birth: _____ School: _____

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 _____

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

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

Stopping Date: ☐ end of school year ☐ Other date/duration: _____

As Needed/Emergency events only ☐ Signs/Symptoms of need: _____

Restrictions and/or important side effects: ☐ No restrictions ☐ Yes. Please describe: _____

* 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

*Requires physician/health care provider approval and signature

Physician/Health Care Provider Signature/Date

Signature of Parent/Guardian / Date

Name of Physician/Health Care Provider: _____

Phone #: _____ Fax #: _____

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 or lack of administration of the above medication. 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.