

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: _____
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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

<i>Physician/Health Care Provider Signature</i>	<i>Date</i>
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<i>Signature of Parent/Guardian</i>	<i>Date</i>
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Name of Physician/Health Care Provider: _____ Address: _____ Phone #: _____ Fax #: _____
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To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.