Bentonville Schools
Health Services

Permission Form for Prescribed Medication

Student Name: ____ DOB____
Grade: _______________ School: ______________________________________
School Year: ___________ Teacher/Homeroom: __________________________

In order to help protect your patient, your written authorization is required for the student to receive the medication listed below in the school setting. This medication is given to maintain or improve health and therefore benefit from school attendance.
Please contact the school RN if there are any questions at: 479______________________________.
The parent may return this form to the school nurse or Fax this form to: 479 ________________________________.

To be completed by Arkansas Physician or Prescribing Medical Professional

Name of Medication: ____

Instructions: (Schedule to be given during school hours)
Dose________________________________
Time(s) ____

Reason for Medication: ____

Form of medication/treatment:
_____Tablet/capsule _____Liquid _____Inhaler _____Injection _____Nebulizer _____Other:__________

Start Date: ____When Forms/Meds received ____Other, as specified: _______________________________

Stop Date: ____End of school year ____Other date/duration: ______________________________

______ FOR EPISODIC/EMERGENCY EVENTS ONLY

Restrictions and/or important side effects: ____NO restrictions
if **YES-**Please describe: ____

Special storage requirements: _____None _____Refrigerate _____Other:________________________

Physician's Signature: ____ Date: _______________________

Physician's Name: ____
Address: ____
Phone: ____
E-mail:____