

Permission Form for Medication Dispensed at School

School: _____ Date form received by school: _____

Student: _____ Date of Birth/Age: _____

Grade: _____ Teacher/Classroom: _____

To Be Completed by the Physician or Authorized Prescriber

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): _____

START: ☐ Date form Received ☐ Other dates: _____

STOP: ☐ End of School Year ☐ Other date/duration: _____

☐ For Episodic Emergency Events Only

Restriction / Side effects: ☐ None anticipated ☐ Yes (please describe) _____

Special Storage Requirements: ☐ None ☐ Refrigerate ☐ Other: _____

Student is both capable & responsible for self-administering medication: ☐ No ☐ Yes, Supervised ☐ Yes, Unsupervised

Student may carry medication on their person: ☐ Yes ☐ No

Additional Information is provided: ☐ On the back of this form ☐ As an attachment ☐ Not applicable

Physician's Signature _____ Date _____

Physician's Name _____

Address _____ Phone Number _____

To be completed by Parent/Guardian

☐ I request that my child, _____, receive the above medication at school according to standard school policy.

☐ I request that my child, _____, be allowed to self-administer the above medication at school according to school policy.

☐ I understand, due to the Health Insurance Portability and Accountability Act (HIPPA), that information regarding my child is confidential. To ensure the best outcome for my child, I hereby authorize that medical information regarding my child, _____, may be shared with other school personnel (in addition to his/her immediate teachers)

Signature _____ Date _____

Parent Name _____ Relationship _____

Return this form to your school office when complete.