Permission Forms 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 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 date: _____

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

Possible reactions or side effects of medicine: 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 ☐ Yes, Unsupervised

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

Student has asthma and has been instructed in self-administration of asthma medications: ☐ Yes ☐ No

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.

TO BE COMPLETED BY PARENT/GUARDIAN FOR NON-PRESCRIPTION MEDICATIONS

As the parent or legal guardian of the student named below, I authorize my child to take the following over-the-counter medication as noted:

Name of Medication: _____ Dosage/Schedule: _____

Possible reactions: _____

Form of medication: ☐ Tablet ☐ Pill ☐ Capsule ☐ Liquid ☐ Inhalant ☐ Other _____

Feedback required ☐ Yes ☐ No If yes, how often? _____

Other Information:

_____

NOTE: OVER –THE-COUNTER MEDICATIONS CAN BE GIVEN NO MORE THAN THREE (3) CONSECUTIVE DAYS WITHOUT A PHYSICIANS ORDER. (09.2241 AP.1)

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FOR ALL MEDICATIONS

I give permission for _____ to receive the above medication at school according to
Student's Name
standard school policy. (Some schools require parent/guardian to bring the medication(s) in its original container.) Signing this form shall 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(s) 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 _____