OWOSSO PUBLICE SCHOOLS | SCHOOL HEALTH SERVICES

PERMISSION FORM FOR ADMINISTRATION OF MEDICATION

Student: ____ Date of birth or age: ______________

Grade: ___________________________ Teacher: ____

School: ___________________________________ Date form received: _______________

- If your child has a significant health condition, please fill out this form and return to the office. If not, please disregard.
- Do not submit to school without accompanying medication.
- All medications should only be handled by adults.

Name of medication: ____

Reason for medication: ____

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Form of medication/treatment –

- ☐ tablet/capsule ☐ liquid ☐ inhaler
- ☐ injections ☐ nebulizer ☐ topical

Other: ____

Instructions (schedule and dose to be given at school):

____

____

Start: ______________________________

Stop –

- ☐ end of school year ☐ other date/duration: ___________
- ☐ for episodic emergencies only

Restrictions and/or important side effects:

- ☐ No - none anticipated ☐ Yes – if yes, please describe below:

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Special storage requirements:

- ☐ none ☐ refrigerate
- ☐ other: ____

Signature: ____ **Date:** _________________

Relationship to student: ______________________________ **Contact phone:** ___________________

Physician's name: ____

Address: ____ **Phone:** ________________________