APPENDIX V-B

PERMISSION FORM FOR MEDICATION

School:

Date form received by the school: _____

Student: _____ Date of birth, or age _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber

Reason for medication: _____

Name of 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 date: _____

Stop: ☐ end of school year ☐ Other date/duration: _____

☐ for episodic/emergency events only

Restrictions and/or important effects: ☐ None anticipated

☐ Yes. Please describe. _____

_____

Special Storage Requirements: ☐ None ☐ Refrigerate

Other: _____

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes - Supervised ☐ Yes - Unsupervised

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Date: _____ Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

Doctor's Signature: _____

To the school: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I _____ give permission for (*name of child*) _____ to receive the above medication at school according to standard school policy. *(Schools require parent/guardian to bring the medication in its original container.)*

Date: _____ Signature: _____ Relationship: _____

Parent/Guardian Phone Numbers: Home _____ Work _____ Emergency