Permission Form for Prescribed or Over-the-Counter Medication

Student's Name: ______________________ **Grade:** _____ **Homeroom/Classroom:** __________

Student's Age: _______ **Date of Birth:** ________________ **School:** ______________

TO BE COMPLETED BY THE PARENT/GUARDIAN OR HEALTH CARE PROVIDER

Policy 09.2241 AP.1 – (Over-the-Counter) –Parents/Guardian shall complete the required form. Medication shall be in original container, dated upon receipt and given no more than three consecutive days without signature from physician/health care provider.

(Prescribed Medication) – Parents/Guardians and Health Care Provider shall complete the required form.

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) ______________________

Starting Date: ☐ date form received ☐ Other, as specified: ______________________

Stopping Date: ☐ end of school year ☐ Other date/duration: ______________________

As Needed/Emergency events only. Signs & Symptoms of need: ______________________

Restriction and /or important side effects: ☐ No restrictions ☐ Yes, Please describe: __________

* Special storage requirements: ☐ None ☐ Refrigerate ☐ Other ______________

* Student is capable of/responsible for self-administering this medication: ☐No ☐Yes ☐Supervised ☐Unsupervised

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

* 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

**Requires physician/health care provider approval and signature*

______________________ ______________________

Physician/Health Care Provider Signature/Date ***Signature of Parent/Guardian / Date***

Name of Physician/Health Care Provider: ______________________

Phone #: ______________ **Fax #:** ______________

FOR ALL MEDICATIONS

I give permission for ______________________ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. 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 ______________

Review/Revised:2/17/09