Permission Form for Prescribed Medication

Student's Name: ____ Grade: ___________

Date of Birth: ______________________ Date form received at school: ______________

To be completed by physician or authorized prescriber for prescribed medication

Name of medication: ____

Form of medication: ○ Tablet/Capsule ○ Liquid ○ Inhaler ○ Injection ○ Nebulizer

○ Other ____

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

____

Start Date: __________ Stop Date: ___________ ○ For episodic/emergency events only

Restrictions and/or important side effects: ____

Special storage requirements: ____

Signature: _____________________________________ Date: ____________

Physicians Name: ____

Physicians Address: ____

Physicians Phone Number: ____

To be completed by parent/guardian

I request that ___________________________________ (name of student) receive the above medication at school according to standard school policy.

Date: ___________ Signature: ____