Administration of Medication Permission Form
For Prescribed / Over Counter Medication

Date received: _____

Student: _____ Age: _____

Grade: _____ Teacher: _____

To be completed by the physician or authorized prescriber.

Reason for medication: _____

Name of medicine: _____

Form of medication / treatment:

☐ Tablet/ capsule ☐ Liquid ☐ Inhaler ☐ Nebulize ☐ Other _____

Instructions (Schedule and dose to be given at school): _____

_____

Start: **On Date form is received** or Other Date: _____

Stop: **End of School Year** or Other Date: _____

☐ **For Episodic/Emergency Events Only**

Restrictions and/or important effects: ☐ None anticipated ☐ Yes _____

Please describe: _____

_____

Special Storage Requirements: ☐ None ☐ Yes _____

Additional Instructions: _____

_____

_____

Date: _____ Signature: _____

Physician's Name: _____

Address: _____

Phone #: _____

Doctor 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. (School requires parent/guardian to bring the medication in its original container.)

Date: _____ Signature: _____ Relationship: _____

Parent/Guardian Phone Numbers (please indicate best number to reach you)

☐ **Home:** _____ ☐ **Cell:** _____ ☐ **Work:** _____