

PERMISSION FORM
for
PRESCRIBED MEDICATION

(PLEASE COMPLETE BOTH SIDES OF THIS FORM)

Date form received by the school: _____
Student: _____
Date of Birth, or age: _____
Grade: _____
Which campus? Museum <input type="checkbox"/> Village <input type="checkbox"/>



To be completed by the physicians or authorized prescriber

Name of medication: _____

Reason for medication (optional) _____

Form of medication treatment:
Tablet/capsule Inhaler Injection Nebulizer Other _____

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



Start: date form received Other dates: _____

Stop: End of school year Other date/duration: _____

Restrictions and/or important side 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:** _____

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Physician's Name: _____
Address: _____ _____
Phone Number: _____

To be completed by parent/guardian

I request that **(name of child)** _____ receive the above medication at school according to standard school policy.

I request that **(name of child)** _____ be allowed to self-administer the above medication at school according to the school policy.

Date: _____ **Signature:** _____

Printed Name: _____

Relationship to Child: _____

This situation and directions have been discussed with the student, who understands when the medication is to be taken and whether they are to self-administer or go to the office to be given the medication.

Yes

Signature of Student: _____

Printed Name: _____

Date: _____