

**Permission Form for Prescribed or Over-the-Counter Medication**

School: \_\_\_\_\_ Date form received by the School: \_\_\_\_\_

<b>Student's Name:</b> _____ <b>Grade:</b> _____ <b>Homeroom/Classroom:</b> _____ <b>Student's Age:</b> _____ <b>Date of Birth:</b> _____ <b>Drug Allergies</b> _____
--

**TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATION**

Name of medication: \_\_\_\_\_ Reason for medication: \_\_\_\_\_

Form of medication/treatment:  Tablet/capsule  Liquid  Inhaler  Injection  Nebulizer  Other \_\_\_\_\_

Describe schedule and dose to be given at school: \_\_\_\_\_

Starting Date:  date form received  Other, as specified: \_\_\_\_\_

Stopping Date:  for episodic/emergency events only  end of school year  Other date/duration: \_\_\_\_\_

Restrictions and/or important effects:  Yes. Please describe: \_\_\_\_\_

**NOTE: In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.**

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

\_\_\_\_\_  
*Physician/Health Care Provider Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*

<b>Name of Physician/Health Care Provider:</b> _____  <b>Address:</b> _____  <b>Phone #:</b> _____ <b>Fax #:</b> _____
--

**To the school:** Please report concerns about medications or the student's condition to the above physician/health care provider.

**TO BE COMPLETED BY PARENT/GUARDIAN FOR NON-PRESCRIPTION MEDICATIONS**

As the parent or legal guardian of the student named below, I authorize my child to take the following over-the-counter medication as noted:

Name of Medication: \_\_\_\_\_ Dosage/Schedule: \_\_\_\_\_

Other Information: \_\_\_\_\_

**Permission Form for Prescribed or Over-the-Counter Medication**

**FOR ALL MEDICATIONS**

I give permission for \_\_\_\_\_ to receive the above medication(s) at school according to 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 of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. 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* \_\_\_\_\_

For student health services/procedures not involving medication only,  
please refer to 09.22 AP.22.

Review/Revised:7/21/11