



Saint Brigid Catholic School Permission Form for Prescription Medication

Student Name: _____
Student Date of Birth or Age: _____
Student Grade Level: _____
Student Teacher/Classroom: _____
Date Form was Received: _____

Name of Medication: _____

Reason for Medication (optional): _____

Form of Medication/Treatment: _____ Tablet/Capsule _____ Liquid
_____ Inhaler _____ Injection _____ Nebulizer Other: _____

Instructions (schedule and dose to be administered on site): _____

Start: _____ Date form Received: _____ Other dates: _____
For Episodic/emergency events only Other date/duration: _____
Stop: _____ End of Program Year

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

Please describe _____

Special storage requirements: _____ None _____ Refrigerate _____ Other _____

Please indicate if you have provided additional information: _____ as an attachment

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

To be completed by parent/guardian:

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

Signature

Relationship

Date