



**2018-19**  
**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