Permission Form for Prescription Medication

Student Name: ______________________________
Student D.O.B. /Age:__________________________ Student Grade: _________________________________
Student Teacher/Classroom: ____________________________

To be completed by student's physician
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: _________________________ Stop Date: _______________________
*Other date/duration: _______________________________

Restrictions and/or important side effects: ☐None anticipated ☐Yes
Please describe _________________________________

Special storage requirements: ☐Refrigerate ☐None
☐Other ________________________________

Please indicate if you have provided additional information:
☐No ☐ Yes (as an attachment on the back of this form)

Physician Name: _______________________________
Physician Address: ______________________________
Physician Phone Number: ___________________________
Physician Signature: _______________________________Date: _______________________________

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

** For Episodic/emergency events only* *Date form received:* ________________________________