Permission Form for Prescribed or Over-the-Counter Medication

PARENT AND HEALTH CARE PROVIDER MUST SIGN

SCHOOL:

Date form received by the school: _____

Student _____ Date of Birth or age _____ Grade _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER:

Reason for Medication: _____

Name of Medication _____

Prescribed Dosage: _____

Time of Day for Dosage:

_____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Possible reactions or side effects of medicine: _____

_____

Start: ☐ Date form received ☐ Other date: _____

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

☐ For episodic/emergency events only

Restrictions and/or important 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 of this form ☐ As an attachment

Date: _____ Signature: _____

Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____

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

I give permission for (name of child) _____to receive the above medication at school according to standard school policy.

Signing this form releases the District and staff members from any liability of any nature that might result from the administration of medication to the student.

Date: _____ Signature of parent/guardian: _____ _____

Telephone Numbers: _____ Home _____ Work _____ Emergency

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

Review/Revised:7/17/2025