Permission Form for Prescribed or Over-the-Counter Medication

School: _____ Date form received by the School: _____

Student's Name: _____ **Grade:** _____ **Homeroom/Classroom:** _____

Student's Age: _____ **Date of Birth:** _____

Allergies to Medications: _____

TO BE COMPLETED PARENT/GUARDIAN

Name of medication: _____ Reason for medication: _____

☐ Prescription medication ☐ Over-the-counter medication provided by parent/guardian

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**

**A student may be permitted to carry medication that has been prescribed or ordered by a physician to stay on or with the pupil due to a pressing medical need. Provided the parent/guardian and physician files the written statement/authorization each year as required by law, a student under treatment for asthma shall be permitted to self-administer medication.

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

Physician's Name: _____

Physician's Signature: _____

Address: _____

Phone #: _____ **FAX #:** _____

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FOR ALL MEDICATIONS

I give permission for _____ *to receive the above medication at school*
Student's Name

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. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders 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 Parent's authorization.

Administrator/designee _____ **Date** _____