FANNIN COUNTY SCHOOL SYSTEM

PERMISSION FOR PRESCRIPTION MEDICATION ADMINISTRATION

Student:_____ Date of Birth:_____ Age:_____

Grade:_____ Teacher:_____ School:_____

A. TO BE COMPLETED BY THE PHYSICIAN

Reason for medication :_____

Name of medication: _____

Form of medication/treatment:
___Tablet/Capsule ____Liquid ___Inhaler ___Injection ___Nebulizer ____ Other

Instructions (Time and Dose to be given at school): _____

_____

Start: _____date form received Other date: _____
Stop: _____end of school year Other date/duration: _____
_____for emergency only As needed (PRN)_____

Restrictions and/or important side effects. Please describe:_____

_____. _____None anticipated

Special storage requirements: _____None _____Refrigerate Other: _____

Date: _____ Physician's Signature: _____

Please Print or Type
Physician's Name: _____ Fax: _____

Address: _____ Phone: _____

Date received at school: _____ Nurse's Signature: _____

B. TO BE COMPLETED BY THE PARENT/GUARDIAN

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

Please indicate if you have provided additional information:___On the back side of this form ___ As an attachment

Date: _____ Parent/Guardian Signature: _____

*** MEDICATION MUST BE DELIVERED TO SCHOOL BY A RESPONSIBLE ADULT IN THE CONTAINER IN WHICH IT WAS DISPENSED BY THE PRESCRIBING PHYSICIAN, LICENSED PHARMACIST OR PHARMACY.**
*** THIS FORM MUST BE COMPLETED EVERY SCHOOL YEAR.**
*** STUDENTS ARE NOT ALLOWED TO TRANSPORT MEDICATIONS.**