Permission Form for Prescribed Medication

Date form received by school: ______________________

Student's Name: ______________________ **Date of Birth:** ______________________

Teacher: ______________________ **Grade:** ______________________

To be completed by the physician or authorized prescriber

Reason for medication: ______________________

Name of medication: ______________________

Form of medication/treatment ☐ **Tablet / Capsule** ☐ **Liquid** ☐ **Inhaler** ☐ **Injection** ☐ **Nebulizer** ☐**Other** ______________________

Instructions (Schedule and dose to be given at school):

____

Start: ☐ **date form received** **Other Date:** ______________________

Stop: ☐ **end of school year** **Other Date:** ______________________

Restrictions and / or important side effects: ☐ **None anticipated**

☐ **Yes** **Please describe:** ______________________

Special storage requirement: ☐ **None** ☐ **Refrigerate**

Other: ______________________

Please indicate if you have provided additional information:

☐ **On the back of this form** ☐ **As an attachment**

Physicians Name & Signature: ______________________

Address: ______________________

Phone ______________________ Date: ______________________

Please report concerns about medications or disease to the above physician.