

**Permission Form for Prescribed Medication and All Over-the-Counter Medication
(including Ointments and Creams)**

School: _____

Date form received by the school: _____

Student: _____ Date of Birth or Age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physicians or authorized prescriber

Name of medication: _____

Reason for medication: _____

Form of medication/treatment: _____

- Tablet/cap Liquid Inhaler Injection Nebulizer
 Other _____

Specific instructions: (Dose/frequency to be given at school): _____

- Start: date form received Other dates: _____
Stop: end of school year Other date/duration: _____
 For episodic/emergency events only

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

Date: _____ Signature: _____

Physician's Name: _____
Address: _____
Phone Number: _____

To be completed by parent/guardian

I request that _____ receive the above medication at school according to standard school policy.

I request that _____ be allowed to self-administer the above medication at school according to the school policy.

Date: _____ Signature: _____ Relationship: _____