APPENDIX V-B
PERMISSION FORM FOR MEDICATION

School:

Date form received by the school: ____________________
Student: ________ Date of birth, or age
Grade: __________Teacher/Classroom: ____________________

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/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 side of this form ☐ As an attachment
Date: ____________ Signature: ____________________

Physician's Name:____________________
Address:____________________
Phone Number:____________________
Doctor's Signature:____________________

To the school: Please report concerns about medications or disease to the above physician.
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. *(Schools require parent/guardian to bring the medication in its original container.)*
Date: ____________ Signature: ____________________ Relationship: ____________
Parent/Guardian Phone Numbers: Home __________ Work __________ Emergency