

SCHOOL MEDICATION PERMISSION FORM

Student Name: _____ Date of Birth _____ Grade/Class _____ Teacher: _____ School _____

TO BE COMPLETED BY HEALTH CARE PROVIDER *Please print clearly and complete ALL sections.*

NAME OF MEDICATION <small>(If medication is for asthma reverse side of form MUST be completed by health care provider and parent.)</small>	STRENGTH	DOSE	ROUTE (circle)	FREQUENCY <small>(include minimum time interval for prn dosing)</small>	DIAGNOSIS	START DATE	STOP DATE
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other _____	_____ OR _____ as needed every _____ hours		___/___/___	___/___/___ OR END OF SCHOOL YEAR (circle)
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other _____	_____ OR _____ as needed every _____ hours		___/___/___	___/___/___ OR END OF SCHOOL YEAR (circle)
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other _____	_____ OR _____ as needed every _____ hours		___/___/___	___/___/___ OR END OF SCHOOL YEAR (circle)

Precautions and/or adverse reactions to report _____

Date: _____ Health Care Provider Signature: _____ Health Care Provider Name _____

Address _____ Phone Number: _____ Fax Number: _____

TO BE COMPLETED BY PARENT OR GUARDIAN: I give my permission for (Name of child) _____) to receive the medications listed above at school according to standard school policy. The school nurse (or other school personnel) involved with the supervision of my child's health has my permission to exchange health information with the health care provider.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone Numbers: Cell _____ Home _____ Work _____ Other _____

Please note: *Medication must be delivered to school by a responsible adult in the container in which it was dispensed by the prescribing health care provider, licensed pharmacist or pharmacy. If the medication or dosage is changed, a new form must be completed. THIS FORM MUST BE COMPLETED EVERY SCHOOL YEAR.*

TO BE COMPLETED BY SCHOOL: Date received at school: _____ School Nurse Signature: _____

Principal Signature: _____

**WOODBURY SIXTH GRADE CAMP
ASTHMA ACTION PLAN**

Student Name _____ Homeroom Teacher _____

TO BE COMPLETED BY PHYSICIAN

Please circle student's known asthma triggers: **pollens** **stress/anxiety** **cold air** **exercise**

allergy (please specify) _____ **other trigger(s)** _____

Current medications for asthma control: _____

Asthma medication to be given at camp: _____

Is student capable and responsible for self-administering this medication? **Yes** **No**

May student carry inhaler? **Yes** **No**

Note: A school district may choose to follow more restrictive procedures regarding student's self-administration.

If an asthma attack occurs, follow these steps:

1. _____
2. _____
3. _____
4. _____

Other special instructions: _____

Date: _____ **Physician's Signature:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that:

- if symptoms are not relieved by steps taken above and indicate the need for emergency care, school personnel will activate the 911 emergency system.
- if my child self-administers asthma medication in locations other than in the presence of the camp nurse, it is my responsibility to review with my child when he/she should seek medical assistance.
- if I am not available at numbers listed on reverse side, contact:

Name _____ **Phone Number** _____

Additional Comments: _____

Parent/Guardian Signature _____ **Date** _____

TO BE COMPLETED BY SCHOOL

Date received at school/camp _____ **Nurse Signature** _____