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 (If medication is for asthma reverse side of form MUST be completed by health care provider and parent.)	STRENGTH	DOSE	ROUTE (circle)	FREQUENCY (include minimum time interval for prn dosing)	DIAGNOSIS	START DATE	STOP DATE
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________________ OR as needed every ______ hours		__/__	__/__ OR END OF SCHOOL YEAR AUG 20, 20___
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________________ OR as needed every ______ hours		__/__	__/__ OR END OF SCHOOL YEAR AUG 20, 20___
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________________ OR as needed every _____ hours		__/__	__/__ OR END OF SCHOOL YEAR AUG 20, 20___

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: ________________________________ Parent/Guardian Name: _______________________ 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:_________________________