PERMISSION FORM FOR PRESCRIBED MEDICATION/TREATMENT

Child's Name_____ Sex_____ Birth Date_____

I request that my child be assisted in taking the medication/treatment listed below at school by authorized school personnel or permitted to medicate/treat herself/himself as authorized by me and the physician (see below).

In order to provide the best care for my child, the school nurse also has my consent to share the information below with appropriate school personnel. Yes_____ No_____

Date_____ Parent/Guardian Signature_____

THE FOLLOWING IS TO BE COMPLETED AND SIGNED BY THE PHYSICIAN:

Diagnosis for which medication/treatment is ordered_____

Name of medication/treatment_____

Dose to be given_____ Time to be administered_____

Form of medication/treatment: Tablet/capsule_____ Liquid_____ Inhaler_____

Nebulizer_____ Other (Specify)_____

Date to start medication/treatment_____
Date to stop medication/treatment_____

For episodic/emergency use only? Yes_____ No_____

Restrictions and/or side effects (please describe)_____

_____

This student is both capable and responsible for self-administering this medication/treatment:

Yes, supervised_____ Yes, unsupervised_____ No_____

If medication is an Inhaler or Bee Sting Kit, this student may carry the medication:
Yes_____ No_____

Additional comments_____

_____

Date_____ Physician's Signature_____

Address_____ Telephone_____