PERMISSION FORM FOR PRESCRIBED MEDICATION/TREATMENT

Child's Name ________________________________ Sex ____ Date of Birth _____________

I request that my child be assisted in taking the medication/treatment described below at school by authorized persons or permitted to medicate/treat herself/himself as also 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 and emergency 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 _____ Injection _____

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 _________________