Permission Form for Prescribed Medication

School:

American Academy of Pediatrics

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 side 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:

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.
(Some schools require **parent/guardians** to bring the medication in its **original** container.)

Date: _____ Signature: _____ Relationship: _____

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