Permission Form for Over-the-Counter Medication

School: ______________________ Date form received: ____________

Student's Name: ______________________ Grade: ________ Age: ________

Date of Birth: ______________________ Classroom: ____________

To be completed by Parent/Guardian for non-prescription medications

As the parent or legal guardian of the student named below, I authorize my child to take the following over-the-counter medication as noted:

Name of medication:	Dosage/Schedule	Other Information

I give permission for (Student name) ______________________ to receive the above medications(s) at school according to standard school policy and expressly hold harmless and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administrations of the above medications9s) unless such is the result of negligence or misconduct on behalf on the school or its employees. For ongoing medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the orders from a physician or health care provider to be followed.

Date: __________ Signature: ______________ Relationship: ____________

Home # __________ Work # ______________ Emergency # ____________

To Be Completed by School Personnel

I/we acknowledge receipt of the foregoing statement and authorization Administrator/designee:

Name: ______________________ Date: ____________

Permission Form for Prescribed Medication

School: ______________________ **Date form received by school:** ____________

Student Name: ______________________ Homeroom Teacher ____________
Grade: ____________ Age: ________ Date of Birth: ________

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for Medication: ______________________
Medication Name: ______________________
Form of Medication/Treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Nebulizer
☐ Injection ☐ Inhaler ☐ Other
Medication Frequency: ______________________
Dose to be given at school: ______________________
Start Date: ☐ Date form received ☐ Other, specify ____________
Stop Date: ☐ For episodic/emergency events only
☐ End of school year
☐ Other date/duration
Storage requirements: ☐ None ☐ Refrigerate ☐ Other ________
Restrictions/Important Effects: ☐ Yes, please describe: ____________

NOTE: In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to the medication, he/she shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.

Student is capable of/responsible for self-administering this medication: ☐ NO ☐ YES
(☐ Supervised ☐ Unsupervised)

Student must carry medication on his/her person: ☐ NO ☐ YES
Please indicate additional instructions: ☐ On back of page ☐ As an attachment
Signature Physician/Prescriber: ______________________ Date: ________
Signature Parent/Guardian: ______________________ Date: ________

The School will inform the physician named below of concerns with regard to student medications and health conditions.
Physician Name: ______________________ Date: ________
Address: ______________________ Fax # ________

Permission Form for Prescribed Medication

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (Student Name) ______________________ to receive the above medication at school according to standard school and health department policy and expressly waive any liability on behalf of the school and health department as a result of administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed.

Date: _______________ Signature: __________________ Relationship: _____________________

Home Phone: ____________ Work Phone: _______________ Emergency Phone: _______________

DATE RECEIVED BY SCHOOL: ____________ **ADMINISTRATOR/DESIGNEE** ____________________
Signature

Review/Revised:06/24/13