MEDICATION PERMISSION FORM

(No Medication will be administered without completion of this form)

Name of Student_____

I request the school nurse, secretary, administrator or other staff person see that my child receive, as needed, the following medication, which I have supplied in the original pharmacy container (showing student name, med. name, administration instructions, and date/or manufacturer's label). I accept ultimate responsibility for monitoring the effects of this medication.

All medication must be taken to the school office, and stored there throughout the day. If there is any change in the medication or dosage, a new permission form must be completed and a new container must be issued by the pharmacy.

Name of medication	**Dosage**	**How given (eye drops, ear drops, orally, etc.)**	**Time(s) of day to give med. or time between doses**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Permission to carry inhaler____Yes____No Permission to self-administer nebulizer____Yes____No

To date, no side effects have been experienced from this med: Yes_____ No ____

Possible side effects:

_____

_____

Name of family doctor: **Office phone number:**

_____ _____

I give permission to contact the prescriber as needed and permission to share medical information with appropriate school personnel.

_____ _____

Parent or guardian's signature **Date**

Parent's phone number _____ _____

home **work**

I have reviewed the following meds and have determined these activities can be done safely for this specific recipient.

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