

PERMISSION FORM FOR PRESCRIBED MEDICATION

PINE-RICHLAND SCHOOL DISTRICT

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: _____

Instructions (Schedule and dose to be given at school): _____

Start: date from received

Other date: _____ For episodic/emergency events only

Stop: end of school year

Other date/duration: _____

Restrictions and/or important side effects: None anticipated.

Yes. Please describe: _____

This student is both capable and responsible for self-administering this medication (for inhaler and epi-pen use only)

No

Yes – Supervised

Yes-Unsupervised (Pending decision of Nurse)***

This student may carry this medication:

Yes

No

Date: _____ Signature: _____ M.D. D.O.

(Physician's Signature)

Physician's Name: _____

Address: _____

Phone Number: _____

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.

***If the above medication is to be carried and self administered by the above named child, I acknowledge that the school bears no responsibility for ensuring that the medication is taken, and I relieve the school district and its employees of responsibility for the benefits or consequences of the prescribed medication. I am aware that any improper use/sharing of the above mentioned medication will result in immediate confiscation of the medication and loss of the privilege to self-administer

Our school district requires parent/guardians to bring the medication in its original container.

Date: _____ Signature: _____ Relationship: _____