Permission Form
for
Prescribed/Over the Counter Medication

Student Name: _____
Grade: _____ Teacher (if elementary): _____
Date of Birth: _____
Parent/Guardian Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Date form received by school: _____

School Building:

_____

To be completed by the Physician or Authorized Prescriber

Name of Medication: _____
Dosage: _____ Prescribed Time: _____
Form of Medication:
☐ Tablet ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer

Restrictions and/or side effects:
☐ None anticipated
☐ Yes, please describe: _____
(Additional information may be documented on reverse side or attached to this document)

☐ For episodic/emergency events only

Start: ☐ date form received Other dates: _____
Stop: ☐ end of school year Other dates: _____

Physician's Signature: _____ Date: _____
Physician's Phone: _____ Fax: _____

To be completed by Parent/Guardian

☐ I request that _____ receive the above medication at school according to standard school policy.

Date: _____ Signature: _____ Relationship: _____

Parent must bring medication to the school office in the original, properly labeled prescription bottle. Make sure dosage is clearly identified. OTC (Over The Counter) medication must be in original container labeled with student's name.

Employee Initials: _____

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