Physician-Parental Permit to Administer Medication at School

Student's Name _____ Grade_____ Teacher_____

Name of Medication _____Dosage_____

Starting date_____ Ending Date _____

Time to be given at school _____

Reason student receiving medication_____

Possible reactions_____

Form of medication __ Tablet __Capsule __Nebulizer

__ Liquid __ Inhaler __Other_____

Feedback requested Yes _____ No_____ How often _____

Physician's Signature Date Telephone

_____

Notice to parents: Ask the pharmacist to provide a second properly labeled, original container that can be left at school.

I would like school personnel to give my child the above medication as prescribed by

Dr. _____as directed on the bottle.

Home phone _____ Work Phone _____

_____

Print Name

_____

Parent/Guardian Signature