**PERMISSION FORM**

for

**Prescribed/Over-the-Counter Medication**

School Building

Student’s Last Name  First Name

Grade       Teacher (if elementary)

Date of Birth

Parent/Guardian Name

Address

Cell Phone #       Home Phone #

Date form received by school

**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:  Date form received Other dates:

Stop Date:  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.

Signature Relationship Date

**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 the original container labeled with the student’s name**.

Employee Initials