PERMISSION FORM FOR PRESCRIBED MEDICATION, INCLUDING ASTHMA

School:

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: ____________________
Prescribed dosage: ____________________
Time of day for dosage: ____________________
Form of medication/treatment:
☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other ____________
Possible reactions or side effects of medicine: ____________________

____

Start: ☐ date form received **Other date:** ____________________
Stop: ☐ end of school year **Other date/duration:** ____________________
☐ For episodic/emergency events only
Restrictions and/or important effects: ☐ None anticipated
☐ Yes Please describe

____

____

Special storage requirements: ☐ None ☐ Refrigerate
Other: ____________________

This student is both capable and responsible for self-administering this medication:
☐ No ☐ Yes-Supervised ☐ Yes-Unsupervised

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:
☐ On the back side of this form ☐ As an attachment

Date: ____________________ **Signature:** ____________________

Physician's Name: ____________________
Address: ____________________
Phone Number: ____________________

Student has asthma and has been instructed in self-administration of asthma medications.

_____ **Yes** _____ **No**

To the school: Please report concerns about medications or disease to the above physician.

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. (*Some schools require parent/guardians to bring the medication in its original container*.)

Signing this form shall release the ____________________ School System and staff members from any liability of any nature that might result from the administration of medication to the student.

Date: ____________ **Signature of parent/guardian:** ____________________**Relationship:** ____________

Telephone numbers: ____________ **Home** ____________ **Work** ____________
Emergency