# PERMISSION FOR PERSCRIBED MEDICATION AT SCHOOL

| STUDENT INFORMATION | |
|---|---|
| Student Name: | |
| Home Address: | |
| Date of Birth: | Grade in School: |
| **LICENSED PERSCRIBER AUTHORIZATION – ONE MEDICATION PER FORM** | |
| Name of Medication: | |
| Dose: | |
| Reason for Medication: | |
| For inhalers, epi-pens and other emergency medication only, it is my professional opinion that this student is responsible and knowledgeable about the proper use of this medication and should be allowed to self-carry YES_____ NO_____ | |
| Medication Start Date: | Medication End Date: |
| Routine/Times to be given during school: | |
| Episodic/Emergency Use Only YES_____ NO_____ | |
| Additional Administration Instructions: | |
| Storage Instructions: | |
| Possible Side Effects/Reactions: | |
| Name of License Prescriber: | |
| Prescriber Phone: | |
| Prescriber Signature: | Date: |
| **PARENTAL PERMISSION** | |
| I request that the school staff give my child the above ordered medication as ordered. I give permission for the prescriber to be contacted by school staff about this order if clarification is needed. | |
| Parent/Guardian Signature: | Date: |
| Parent Phone Number: | |
| **MEDICATION MUST BE STORED IN ORIGINAL PRESCRIBER'S PACKAGING** | |