OLMC PRESCRIBED MEDICATION PERMISSION FORM

Student: ________________________________Grade: _______Date of Birth: ________________

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of Medication: ____

Reason for Medication: ____

Form of medication/treatment: ____tablet/capsule ____liquid ____ injection____

inhaler ____ nebulizer _____ other (please specify)_____________________________

Instructions (list specific times and dosage to be given at school): _________________________

____

Start Date: ________________________ Stop Date: _________________________________

Restrictions and/or important side effects: ____

Physician's Signature: ____________________________________ Date signed: ____________

Physician's name (printed): _______________________________ Phone: _________________

Address: ____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I give permission for my child, named above medication at school according to standard School policy. Medication must be brought in the original container with child's name, dose & instructions. _____________Yes _______________ No

I give permission for my child, named above, to transport his/her medication to and/or from school as needed during the school year. ________Yes _____________No

Parent/Guardian Signature **Date**

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