Permission Forms for Medication

Student's Name: _____ Grade: _____ Age:_____ Date of Birth: _____/_____/_____

School: _____

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

Procedure 09.2241 AP.1 – Medication shall be in the original container, dated upon receipt. Prescribed medication/self-administration/over-the-counter medication needed for longer than three (3) days requires a parent/guardian and Health Care Provider to complete the required form.

Name of medication:_____	**Name of medication:**_____
Reason for medication:_____	**Reason for medication:**_____
Instructions: Time:_____ **Dose:**_____	**Instructions: Time:**_____ **Dose:**_____
Start Date:_____/_____/_____ **Stop Date:**_____/_____/_____	**Start Date:**_____/_____/_____**Stop Date:**_____/_____/_____
Signs & symptoms of emergency administration: _____	Signs & symptoms of emergency administration:_____
_____	_____
Restriction and/or important side effects: ☐ No restrictions ☐ Yes. Please describe:_____ ☐ Other *Student must carry this medication on his/her person and **self-administer** during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** ☐ Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to **self-administer (*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)	Restriction and/or important side effects: ☐ No restrictions ☐ Yes. Please describe:_____ ☐ Other *Student must carry this medication on his/her person and **self-administer** during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** ☐ Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to **self-administer (*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)

_____***(MD INITIALS)** The above named student has been instructed on the care, storage, dosage, and use of the above medication(s) and has sufficient knowledge and ability - to **self administer** the medication(s) in the school setting and while on field trips.

_____
Physician/Health Care Provider Signature/Date

Physician Practice name:_____

Address:_____

Phone: (___)_____ Fax: (___)_____

PARENT AUTHORIZATION FOR ABOVE LISTED MEDICATIONS.

I give permission for _____ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

I/we reviewed the statement and authorization for completion.
Administrator/designee _____ Date _____