STUDENTS 09.2241 AP.21

Permission Form for Prescribed or Over-the-Counter Medication

School:I	Date form received by the School:					
Student's Name: Grad Student's Age: Date of Birth:			meroom/Classroom:			
nless, and waive any liability on beneff of, the school or its enough	amel bis	ef gitte	ges lan yang kumba kadhalis			
TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER						
Name of medication: Reason for medication:						
☐ Prescription medication ☐ Over-the-counter medication provided by parent/guardian						
Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other						
Describe schedule and dose to be given at school:						
Starting Date: ☐ date form received ☐ Other, as specified:						
Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration:						
Restrictions and/or important effects: Yes. Please describe:						
NOTE: In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.						
Special storage requirements: ☐ None ☐ Refrige	rate	□ Other				
Student is capable of/responsible for self-administering this med	ication:	□No	☐Yes ☐Supervised ☐Unsupervised			
Student has been instructed in self-administering the medication:	:	□No	□Yes			
Student must carry this medication on his/her person:		□No	□Yes			
Please indicate additional information: □ On the back side of this form □ As an attachment						
Physician/Authorized Prescriber's Signature			Date			
Signature of Parent/Guardian for Over-the Counter Medical	tion		Date			
Physician's Name:	Add	lress:				
Phone #:Fax	#:					

To the school: Please report concerns about medications or the student's condition to the above physician.

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	Тов	E COMPLETED B	Y PARENT/GUARDIA	AN	
I give permission for	Student's	Name	to receive the ab	pove medication at school according to	
and agents concern the result of neglige	icy and expressly hold ing any injuries or reac ence or misconduct on	harmless, and we tions resulting f behalf of the sch	rom administration nool or its employee	n behalf of, the school or its employee of the above medication unless such is es. I understand that I have the ultimate to enable the physician's orders to be	
Date:	Signature:	roleđaj 🖸 blopi.	f Ci-simpeoVeldeT	Relationship:	
Home Phone:		Phone			
	Тов	COMPLETED BY	SCHOOL PERSONN	HEL	
	G Other			Review/Revised: 10/24/05	
				Please indicate additional artismat	
	ă.				
				Signature of ParantiGenerium J	