IF APPLICABLE

Permission Form for Prescribed Medication (Short and Long Term Medications)

Allendale Public Schools

Date form received by the school: _____

Student: _____ Date of Birth, or age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physicians or authorized prescriber

Name of medication:_____

Reason for medication: (OPTIONAL) _____

Form of medication/treatment:

◯ Tablet/capsule ◯ Liquid ◯ Inhaler ◯ Injection ◯ Nebulizer ◯ Other

Instructions (Schedule and dose to be given at school): _____

Start: ◯ date form received Other dates: _____

Stop: ◯ end of school year Other date/duration: _____

Restrictions and/or important side 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: _____

To be completed by parent/guardian

I request that (name of child) _____ receive the above medication at school according to standard school policy.

I request that (name of child) _____ be allowed to self-administer the above medication at school according to the school policy.

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