

WARREN COUNTY PUBLIC SCHOOLS

Permission Form for Prescribed Medication

DO NOT WRITE IN THESE SPACES OR SIGN HERE

Student: _____ School: _____ School Year: _____

Student age: _____ Date of Birth: _____ Grade: _____ Homeroom/Classroom: _____

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Name of medication: _____

Reason for medication: _____

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, as specified: _____
 Stop: End of school year Other date/duration: _____

For episodic/emergency events only

Restrictions and/or important side effects: No restrictions
 Yes. Please describe: _____

Special storage requirements: None Refrigerate _____

Other: _____

Physician's Name _____

Date _____ Phone _____ Address: _____

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I give permission for (name of child) _____ is to receive the above stated medication at school according to standard school policy. I release the _____ School Board and its employees from any claims or liability connected with its reliance on this permission.

(Parent/guardians to bring the medication in its original container.)

Date: _____ Signature: _____ Relationship: _____

Home phone: _____ Work phone: _____ Emergency phone: _____

Date: _____	Number of pills received: _____	Initials: _____
Date: _____	Number of pills received: _____	Initials: _____
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Date: _____	Number of pills received: _____	Initials: _____
Date: _____	Number of pills received: _____	Initials: _____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization:

_____ School Personnel Signature