WARREN COUNTY PUBLIC SCHOOLS
Permission Form for Prescribed Medication
TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Student: _____ School: _____ School Year: _____

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

Allergies: _____

Name of medication: _____
Reason for medication: _____

Form of medication/treatment (Circle One):
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: _____

Restrictions and/or important side effects: _____ No restrictions Yes
If yes, please describe: _____
_____

Special storage requirements: None Refrigerate Other: _____

Physician's Name _____
Date _____ Phone _____ Fax Number: _____

I give permission for (name of child) _____
to receive the above stated medication at school according to standard school policy. I release the Warren County Board of Education and its employees from any claims or liability connected with its reliance on this permission. **(Parent/guardian 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:

Authorized School Personnel
Signature: _____