Medication Administration Permission Form

(Including Inhalers and Injectors)

School Name: _____ Date of Birth: _____

Student Name: _____ Phone Number: (___) _____

Address: _____ Grade: _____

By signing below, I request that the named student receive the medication noted below from school personnel according to school policy. I agree to deliver the medication timely to the school and in its original labeled container. I will notify the school if the medication is changed or eliminated. I understand that it is the student's responsibility to report on time for this medication. I fully release the school, its employees, and board from all liability related to the administration of this medication and from any injury arising from the student's self-administering or self-possession of this medication.

_____ _____ _____

Custodial Parent/Guardian Signature Date Relationship

Name of Medication: _____

Form of Medication:

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection
☐ Nebulizer ☐ Other _____

Schedule and Dosage to be given: _____

Start Date: _____ Stop Date: _____

OR

☐ For Episodic/Emergency events only

Restrictions or Adverse Reactions (to report to physician): _____

_____

Special Storage Requirements: ☐ None ☐ Refrigerate ☐ Other _____

Self-Administering: This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes – Supervised ☐ Yes – Unsupervised

Self-Possession: This student may carry this medication: (Check "yes" only if self-possession is critical to student's wellbeing–see note below)

☐ Yes ☐ No

Note: to prevent the medication from theft or misuse by other students, the school will not allow students self-possession unless carrying the medication is critical to the student's wellbeing. Physician's signature required.

Inhaler and Injector Use Only (Physician signature required below):

☐ Emergency Care Plan prepared by Physician is attached

Procedures to follow if medication does not provide the expected relief: _____

_____

Adverse reactions for unauthorized user: _____

PHYSICIAN SIGNATURE REQUIRED IN BELOW CIRCUMSTANCES (By signing, agrees to all information provided above):

- Any possession or administration of an inhaler or epinephrine injector
- Any self-possession or self-administration of any medication

_____ _____ _____

Signature of Physician Printed Name Date

_____ (___) _____

Address Phone Number