St. Stephen Martyr School

PERMISSION FORM FOR PRESCRIBED MEDICATION

Date form received by the school: _____

Student: _____

Grade: _____ Date of birth: _____

Teacher:

_____

Reason for medication: _____

Name of medication: _____

Form of medication or treatment:

☐ tablet or capsule ☐ liquid ☐ inhaler ☐ injection ☐ nebulizer

Instructions (schedule and dose to be given at school)

Start: ☐ date form received Other date: _____

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

☐ for episodic/emergency events only

Restrictions and/or important effects:

☐ None anticipated ☐ Yes. Please describe_____

Special storage requirements: ☐ None ☐ Refrigerate

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

Physician's Name: _____

Address: _____ Phone Number: _____

Doctor's Signature_____

☐ No ☐ Yes-supervised ☐ Yes-unsupervised

To be completed by parent/guardian:

I give permission for (name of child) _____to receive the above medication at school according to standard school policy (Schools require parent/guardian to bring the medication in its original container).

Date:_____ Signature_____

Relationship:_____

Parent/Guardian Phone Numbers:

Home: _____ Work:_____ Emergency:_____