CHILDREN’S SCHOOL/MIDDLE SCHOOL PERMISSION FOR MEDICATION

Complete only if your student requires a medication other than Acetaminophen, Ibuprofen and Benadryl, Pepto Bismol - during the school day. A **physician’s signature is required** for all medication administration other than the above OTC medications. **All medications must be delivered to the Infirmary Coordinator. Students may not self-administer their medication.** A parent may administer medication to his or her own child at any time during the day.

Name of Student____________________________ Grade ____________

Medication __________________________________________

Dosage _______________________________________________________

Purpose of medication ___________________________________________

Time of day medication is to be given ______________________________

Possible side effects ____________________________________________

Anticipated number of days medication is to be given __________________

Will medication need refrigeration? ___________________

I give my permission for the Infirmary Coordinator, or other trained faculty member, to administer the above medication as ordered. I understand it is my responsibility to provide this medication in the originally labeled pharmacy container.

Signature of Parent ___________________________ Date ___________

*Signature of Physician. ______________________ Date ___________

Responsible students in grades 3-8, who need to carry an asthma inhaler, as noted above, may do so with parent and physician permission. Please read the following information and sign below.

As the parent/guardian of _________________ (student name), I give my permission for him/her to carry and self-administer the above named inhaler. As the parent/guardian, I accept responsibility for any misuse of this medication. I have discussed this procedure with my student/patient.

Signature of Parent: ______________________________ Date: __________

*Signature of Physician: ___________________________ Date __________