

# PERMISSION FORM FOR PRESCRIBED MEDICATION



School Name:	Date Received:
Student Name:	Date of Birth:     /     /
Grade:	Teacher / Classroom:

## TO BE COMPLETED BY PHYSICIAN

Name of Medication (List only 1 medication per form): \_\_\_\_\_

Tablet/Capsule     Liquid     Inhaler     Injection     Nebulizer     Other \_\_\_\_\_

Instructions (*Dosage of medication and time to be administered*): \_\_\_\_\_

For episodic/emergency events only    Comment: \_\_\_\_\_

Conditions for which medication is being prescribed: \_\_\_\_\_

Restrictions and/or important side effects:     None anticipated     Yes, please describe: \_\_\_\_\_

Physician's additional comments: \_\_\_\_\_

Order Start Date: \_\_\_\_\_ Order End Date: \_\_\_\_\_

*(If no end date is indicated, medication orders will expire at the end of the current school year)*

Special storage instructions:     None     Refrigerate: \_\_\_\_\_     Other: \_\_\_\_\_

This student is both capable and responsible for self-administering this medication:     No     Yes – Supervised     Yes – Unsupervised

This student may carry this medication:     No     Yes

Please indicate if you have provided additional information:     On the back of this form     As an attachment (Treatment Plan)

*NOTE: To participate in Medicaid School-Based Services, a valid prescription MUST be signed by a physician and include the date prescription was signed by physician, physician's name, address, telephone number and NPI number. Stamped signatures and prescriptions signed by a nurse practitioner or physician assistant are invalid for school-based services.*

Physician's Signature: \_\_\_\_\_ Print Physician's Name: \_\_\_\_\_ NPI #: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

## PARENT / GUARDIAN AUTHORIZATION

I hereby request that school personnel give my child \_\_\_\_\_ the medication ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to the medication, including those administered pursuant to P.A. 451 of 1976, section 1178. Staff may contact the physician regarding administration of the medication if necessary. I am responsible for transporting the medication to my child's school.

I hereby request that school personnel would allow my child \_\_\_\_\_ to self-administer medication ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to the taking of such medication. Staff may contact the physician regarding administration of the medication if necessary. I am responsible for transporting the medication to my child's school.

Parent or Guardian Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Telephone Number: \_\_\_\_\_