



**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 Nurse. 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 school nurse, 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 \_\_\_\_\_ Phone \_\_\_\_\_

**\*Signature of Physician.** \_\_\_\_\_ **Date** \_\_\_\_\_ **Phone** \_\_\_\_\_

**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** \_\_\_\_\_