Roscoe Collegiate ISD

PERMISSION FOR MEDICATION ADMINISTRATION

Student:_____ DOB:_____ Grade: _____

Date form received by the school:_____ Homeroom Teacher:_____

TO BE COMPLETED BY THE PHYSICIAN / AUTHORIZED PRESCRIBER:
(Physician signature required for ALL medication, including over the counter medication if given at school.)

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:

Tablet/capsule Liquid Inhaler Injection Nebulizer Other: _____

Start: _____ Stop: _____

Instructions (Schedule and dose to be given at school):_____

For episodic/emergency events only ___ Yes ___ No

*Restrictions and/or important side effect*s (if yes describe): __Yes __ No

_____

Special storage requirements: ___None___ Refrigerate __Other (please describe)_____

Please indicate if you have provided additional information: On the back of this form / As an attachment

Physician Name: _____ Physician Signature: _____

Phone Number: _____ Address: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for (name of child) _____ to receive the above medication at school from its original labeled container according to standard school policy.

Date: _____ Signature: _____