

**PERMISSION FORM FOR MEDICATION - Holy Name Catholic School**

Date form received by school \_\_\_\_\_

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ Teacher/Homeroom \_\_\_\_\_

Name of medication \_\_\_\_\_

Reason for medication (Optional) \_\_\_\_\_

Form of medication/treatment: (Circle one)

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

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

Start: \_\_\_\_\_ Date form received                      Other dates: \_\_\_\_\_

Stop: \_\_\_\_\_ End of school year                      Other date/duration: \_\_\_\_\_

Restrictions and/or important side effects:

\_\_\_\_\_ None anticipated    \_\_\_\_\_ Yes. Please describe: \_\_\_\_\_

Special storage requirements:

\_\_\_\_\_ None    \_\_\_\_\_ Refrigerate    Other: \_\_\_\_\_

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

\_\_\_\_\_ No    \_\_\_\_\_ Yes-Supervised    \_\_\_\_\_ Yes-Unsupervised

The student may carry this medication:    \_\_\_\_\_ No    \_\_\_\_\_ Yes

Please indicate if you have provided additional information:

\_\_\_\_\_ On the back side of this form                      \_\_\_\_\_ As an attachment

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

I request that (name of child) \_\_\_\_\_ receive the above medication at school according to the standard school policy.

I request that (name of child) \_\_\_\_\_ be allowed to self-administer the above medication at school according to the school policy.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

**\*\*\*\*\*NOTE: ALL MEDICATION MUST BE IN ITS ORIGINAL CONTAINER WITH LABELING INTACT\*\*\*\*\***