

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ School Year: _____

Date form received _____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization.

Student Name: _____ Student age: _____ Date of

Birth: _____ Grade: Homeroom/Classroom: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER:

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:

Tablet/capsule Liquid Inhaler Injection Nebulizer Other

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

Start: Date form received Other, as specified: _____

Stop: End of school year Other date/duration: _____

For episodic/emergency events only

Restrictions and/or important side effects: No restrictions

Yes. Please describe: _____

Special storage requirements: None Refrigerate

Other: _____

Physician's Signature _____

Physician's Name: _____

Date: _____ Phone _____

Address: _____

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child) is to receive the above stated medication at school according to standard school policy. I release the _____ School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date: _____ **Signature:** _____ **Relationship:**

Home phone: _____

Work phone: _____

Emergency phone: _____