CLEVELAND HEIGHTS-UNIVERSITY HEIGHTS
CITY SCHOOL DISTRICT

School Year: _______________
Nurse Fax: _________________

PERMISSION FORM FOR PRESCRIBED MEDICATION

School___________________ Date received by the school___________

Student_____________________________________ ID#______________________ DOB________________

Address_____________________________________Grade______Advisory teacher____________________

To be completed by the PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of medication: ______________________________ **Reason:**_____________________

Form of medication / treatment: □ Inhaler □ Nebulizer □ liquid □ tablet/capsule

Dosage and Schedule of medication ____

Route of administration________________________________

START: □ When form received □ Other date: _________________________
STOP: □ End of school year □ Other date/duration: ____________________

Restrictions and/or important side effects:____
Special storage requirements: □ none □ refrigerate □ Other: ____________________

This student is both capable and responsible for self-administering this medication:
□ NO □ YES, but supervised □ YES, Unsupervised

This student may carry this medication: □ No □ Yes

Please indicate if you provided additional information as an attachment: yes___ no____

Date________________ **Provider Signature**____

Physician name____

Address____

Phone number______________________________**Fax Number:** __________________________________

To the school: Please report concerns about medications or disease to the above physician.

To be completed by the PARENT/GUARDIAN

I give permission for (student)_________________________________to receive the above medication at school according to standard policy. The medication must be brought to school in the original container from the pharmacy.

Date___________ Signature _________________________________ Relationship______________________

Revised 06/2022