School year: ______________________

Cleveland Heights-University Heights City Schools
Department of Student Services

PERMISSION FORM FOR PRESCRIBED MEDICATION

School: ______________________ NURSE FAX: ___________________

Date form received by the school: _____________________

Student: ____ ID# _________ Birthdate: _________

Grade: ____________ Advisory Teacher: ____________________________

To be completed by the PHYSICIAN OR AUTHORIZED PRESCRIBER:

Reason for medication: ____

Name of medication: ____

Form of medication / treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (schedule and dose to be given at school): ______________________________________

START: ☐ When form received ☐ Other date: _______________________________

STOP: ☐ End of school year ☐ Other date/duration: _________________________

☐ For episodic / emergency events only

Restrictions and/or important side effects: ☐ none anticipated ☐ yes – please describe: _____

____

Special storage requirements: ☐ none anticipated ☐ refrigerate

☐ Other: ____

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

☐ NO ☐ YES, supervised ☐ YES, Unsupervised

This student may carry this medication: ☐ Yes ☐ No

Please indicate if you have provided additional information:

☐ On the back of this form ☐ as an attachment

Date: _________ Signature: ____

Physician's Name: ____

Address: ____

Phone 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 (name of child) ______________________________________ to receive the above medication at school according to standard policy. The medication must be brought to school daily in the original container from the pharmacy.

Date: _________ Signature: ______________________________________ Relationship: ________

1/06 Kirby