HOLGATE LOCAL SCHOOLS
ELEM. PHONE: 264-5231- MS/HS. PHONE: 264-2521
FAX 264-1965

PERMISSION FORM FOR PRESCRIBED MEDICATION

For School Office Use:
Date form received by the school _____
Student: _____ Date of Birth _____Age _____
Student Address: _____
Grade _____ Teacher/Classroom _____

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: ____Date 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 ____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 ____no ____yes
Any severe reactions that should be reported to the physician
_____
Any severe reactions that may occur to another student for whom an inhaler is not prescribed.
_____
Any emergency. action that should be taken
_____
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: _____
Alternate Phone Number: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____
to receive the above medication at school according to standard school policy.
Holgate Schools requires parent/guardians to send the medication in its original container.

Date _____Signature _____Relationship_____ _____