St. Louis School

PERMISSION FORM FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Student_____ Date of Birth_____ Class_____

Allergies_____ Date Form Initiated_____

TO BE COMPLETED BY PHYSICIAN

Name of Medication:_____ **Dose:**_____

Time to be given:_____ **If PRN, list frequency:**_____

Reason for Medication_____

Form of Medication:

_____Tablet/capsule _____ Liquid _____Inhaler _____ Nebulizer _____Other

Start Date:_____ **Stop Date:**_____

Severe reactions to be reported to the Physician:_____

Special Instructions:_____

Date:_____ **Physician's Signature**_____

Physician's Name (printed)_____ **Phone**_____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for my child to receive medication at school according to the St. Louis School policy listed in the handbook and as instructed by the physician. I agree to:

- Assume responsibility for safe delivery of medication to the school with my child's name written on the medication. (Over the counter medications will be unopened)
- Have a new form completed by the physician if the medication or dosage is changed.
- Notify the school if my child received a PRN medication before arriving to school.

Parent/Guardian Signature:_____ **Date**_____

Daytime Phone Number_____

***THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR**

FOR SCHOOL USE: Physician_____ Parent/Guardian_____ School Nurse Initials_____

Revised 01/20/09