Minnewaska Area Schools
Medication Permission

OFFICE USE ONLY
Date form received by school _____

School Year _____

STUDENT INFORMATION

Name _____ Grade _____ Age _____

Teacher/Classroom _____

Parent(s)/Guardian(s) Full Name _____

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 _____

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

☐ Please report any concerns about medications or disease to the below physician.

Physician's Name _____

Clinic _____ Phone Number _____

Signature _____ Date _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ Grade _____ to receive the above medication at school according to standard school policy. I understand Minnewaska Area Schools requires parent(s)/guardian(s) to bring the medication in its original container.

Signature _____ Date _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____