School Administrative Unit #9

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Permission for Medication Administration in School

Child's Name: _____

Date of Birth: _____ **Grade:** _____

Date: _____ **Teacher:** _____

Diagnosis:

_____

_____

Medication(s) Prescribed: (generic or brand name)

_____

_____

Dosage, Route, Times of Administration, Duration of Treatment:

_____

_____

Modification(s) of School Program:

_____

_____

Side Effects to be Noted:

_____

_____

Student has permission to self-carry their asthma inhaler: YES NO

_____ _____

Physician Name (Printed) Physician Signature

_____

Physician Phone Number

I authorize my child's school to assist my child in taking medication during school hours and agree that I will not hold liable any member of the school staff and/or individual in an official capacity designated by the School Administration to assist my child in taking the medication noted above.

_____ _____

Parent / Guardian Name (Printed) Parent / Guardian Signature

_____

Emergency Phone Number