Yamhill-Carlton
SCHOOL DISTRICT
promoting excellence in education

Permission Form for Prescribed Medication

Student: _____ DOB: _____ Date: _____
Grade: _____ Teacher/Classroom: _____

***To Be Completed By the Parent, 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

Please Indicate If You Have Provided Additional Information:
☐ On the Back Side of This Form ☐ As an Attachment

Date: _____ Signature: _____

Physician's Name: _____ Phone Number: _____

***To the School: Please Report Concerns About Medications or Disease to the Above Physician.

***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.

Date: _____ Signature: _____ Relationship: _____