YARMOUTH

"Empowering students"

MEDICATION PERMISSION FORM

MEDICATIONS MUST BE BROUGHT TO SCHOOL IN THE **ORIGINAL CONTAINER BY THE PARENT/GUARDIAN.** (Pharmacies will provide an extra container if needed) NO MEDICATION will be administered without this information.

Student's Name: _____ Grade:_____ Teacher:_____

Name of Medication: _____ Dose: _____

Reason for Medication: _____Time(s) need to be given: _____

____Tablet/capsule ____Liquid ____ Inhaler ____Injection ____Nebulizer

Start on date (____/____/____) Stop on date (____/____/____)

Restrictions and/or possible side effects: _____ None anticipated _____ Yes, please

describe _____

Permission to contact prescribing physician:
I give my permission for the school to contact the prescribing provider to obtain information about medication and the administration schedule.

I understand that the above medication may be administered by the school nurse or a designated unlicensed staff member as permitted by law. The school may refuse any requests contrary to school policy.

Medication Removal:
At the end of the school year or the last student day, I understand that I must pick up my child's medication or it will be discarded.

Parent/Guardian signature: _____ Date: _____

Prescribing provider's name: _____

_____ _____

medical provider's signature Date

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