Brodhead School District Administration Permission Form

PRESCRIPTION MEDICATION

Name of Student_____**Grade**_____

Medication	Dosage	Route	Time/Frequency	Duration

Reason for medication (diagnosis)_____

Possible side effects_____

For Inhaler Medications only:
Is the student knowledgeable about his/her asthma medication? Yes_____No_____
Has the student demonstrated proper technique in self-administration? Yes_____No_____
If needed, how soon can medication dose be repeated?_____
It is my professional opinion that the above student may carry and use this inhaled medication independently?
Yes ____ No____

PHYSICIAN SIGNATURE_____**DATE**_____
Phone _____**Address**_____

I give my permission for school personnel to give the above medication as directed and communicate with the physician if necessary.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

- **Medication MUST be in the original prescription bottle. The label must be current.**
- **Inhalers must have prescription labels attached.**
- **Written notice of dose change is required with M.D. and Parent signature.**

NON-PRESCRIPTION MEDICATION

NAME OF STUDENT_____**GRADE**_____

MEDICATION_____**DOSAGE**_____**REASON**_____

WHEN TO GIVE_____**HOW OFTEN TO GIVE**_____

I give my permission for school personnel to give the medication as directed.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

Medication MUST be in the original bottle. Please, no envelopes or plastic bags. This is to protect the safety of your child.