RN-M003
Revised: 0815

South-Western City School District

School Medication Permission and Instruction Form

School: ______________________ Phone: ______________________
Address: ______________________ Fax: ______________________

This form must be completed with physician and parent/guardian signatures. The required written information must be received, before any medication can be administered at school AND/OR, if the student is carrying an inhaler/epipen.

Parent Permission Date: ______________________
Student's Name: ______________________ Birth date: ______________________
Address: ______________________ Home Phone: ______________________
Daytime Phone: ______________________
School: ______________________ Grade: __________ Teacher: ______________________

I hereby request and give permission to the PRINCIPAL or his/her DELEGATE (school nurse or other responsible person) to administer the medication routine described below and to communicate as needed with the prescribing physician. I understand that I am responsible for delivering the prescribed medication to the student's school in its original container (as labeled from the pharmacy) and for assuring that an adequate supply of the medication has been provided to the school.

If the Health Care Provider has indicated that the student should be permitted to carry an inhaler and/or epipen at school, I understand that the student is responsible for its proper maintenance and use. I understand that if the student is found to have shared his/her medication with other students or otherwise abused the medication or device, the student will not be permitted to carry his/her inhaler and/or epipen at school, and disciplinary action may occur. I understand, and have informed the student, that (s)he must notify the school bus driver, principal, nurse or teacher if his/her inhaler/epipen is lost or is taken from him/her by another person.

Parent Signature: ______________________

Physician's Direction
The above named student is under my care and should receive the following.
Medication: ______________________ Dosage: __________ Route: ______________________
at these times: ______________________
Other specific instructions for administration: ______________________

Inhaler/Epipen Only:
The student knows and understands the proper use of his/her inhaler/epipen ☐ Yes ☐ No
The student should be allowed to carry it on his/her person. ☐ Yes ☐ No
Possible side effects to watch for: ______________________

Expiration date of this request: ______________________
Doctor requests teacher's comments
☐ Yes: Please observe the following: ______________________
☐ No: Teacher comments unnecessary

Physician Name (Please print or type): ______________________
Physician Signature: ______________________
Physician Phone Number: ______________________
Physician Fax Number: ______________________
Date: ______________________