EAST NEWTON RVI SCHOOL DISTRICT
PERMISSION FOR ADMINISTRATION OF MEDICATION

Students name: _____ Sex: _____ Birth date: _____

Grade: _____ Teacher: _____

MEDICATION/PRESCRIPTION INFORMATION

_____Prescription medicine _____Over-the-Counter (OTC) provided by parent/guardian

Has student been given the first dose of this medication? _____Yes _____No

Name of medication(s): 1)_____ 3)_____

2)_____ 4)_____

Reason for medication: _____

Form of medication/treatment: _____Tablet/Capsule _____Liquid _____Inhaler _____Injection _____Nebulizer _____Other

Schedule and Dose to be given at school: _____

If "as needed", maximum dosage to be given at school: _____

Are there restrictions and/or important side effects? _____Yes _____No

If yes, please describe: _____

Storage requirements: _____None _____Refrigerate _____Other

I give permission for __ _____ (student's name) to receive the above medication at school.

Parent/Guardian signature: _____ Date: _____

Home phone: _____ Work phone: _____ Emergency phone: _____

I also give the school district permission to contact the student's physician directly to provide information on the student's condition. I understand I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease.

Physician's name: _____ Phone: _____

Address: _____ Fax: _____

Parent/Guardian signature: _____ Date: _____