PERMISSION FOR PRESCRIPTION MEDICATIONS

Loudonville-Perrysville Schools
Authorization Form

Student:_____Date of Birth:_____

Grade: _____ Homeroom Teacher: _____

PRESCRIPTION MEDICATION----------TO BE COMPLETED BY PHYSICIAN

Reason for medication: _____

Name of medication: _____

Form of medication/treatment:

_____Tablet/capsule ____liquid _____Inhaler Other: _____ Dosage:_____

Instructions (Schedule and dose to be given at school): _____

_____

For emergency only (explain): _____

Restrictions and/or side effects: _____

Storage requirements: _____

Is this student both capable and responsible for self-administering this medication? _____

Comments: _____

_____

Physician name: _____

Physician Address: _____

Physician Phone Number: _____

Physician signature and date: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for _____ to receive the above prescription medication at school according to the policy of the Loudonville-Perrysville Board of Education.

Parent/Guardian signature and date:_____

PERMISSION VOID AT END OF CURRENT SCHOOL YEAR