

**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***