

St. Leonard Parish School
Permission Form for Medication

Date Received: _____

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Date form received by the school: _____

Student: _____ Date of birth, or age _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber

Reason for medication: _____

Name of medication: _____

Form of medication/treatment:

Tablet/capsule Liquid Inhaler Injection Nebulizer Other _____

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

Start: date form received Other date: _____

Stop: end of school year Other date/duration: _____

for episodic/emergency events only

Restrictions and/or important effects: None anticipated

Yes (Please describe) _____

Special Storage Requirements: None Refrigerate

Other: _____

This student is both capable and responsible for self-administering this medication:

No Yes - Supervised Yes - Unsupervised

This student may carry this medication: No Yes

Please indicate if you have provided additional information:

On the back side of this form As an attachment

Physician's Name: _____

Address: _____

Phone Number: _____

Doctor's Signature: _____

To the school: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I give permission for (*name of child*) _____ to receive the above medication at school according to standard school policy. (*Schools require parent/guardian to bring the medication in its original container.*)

Date: _____ Signature: _____ Relationship: _____

Parent/Guardian Phone Numbers: Home _____ Work _____ Emergency _____