PRESCRIBED MEDICATION PERMISSION FORM
FOWLER HIGH SCHOOL

Student: _____ Date of Birth: _____

Grade: _____ Parent/Guardian Name: _____

I request that (name of child) _____ receive the listed medication at school by school personnel following the directions provided by the listed physician/prescriber in accordance to school policy.

AND/OR

I request that (name of child) _____ be allowed to self-administer the listed medication at school following the directions provided by the listed physician/prescriber in accordance to the school policy.

Date: _____ Parent/Guardian Signature: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER:

Name of Medication: _____

Reason for Medication: _____

Form of medication treatment (Please Circle):

Tablet/Capsule Liquid Inhaler Injection Nebulizar Other_____

Instructions (Schedule & dose for school employee to administer): _____
_____
_____

Start Date of disbursement of medication: _____

Ending date of disbursment of medication: _____

Restrictions or possible side effects: _____
_____

Special Storage Requirements: _____

Physicians Name: _____

Address: _____

Contact Number in Case of Emergency: _____

Date form received by school: _____ This information expires on June 30, _____