Waldron Elementary Middle School
Permission Form Dispensing Medication

School:______________________ Date Form Received by School________________

Student Name:______________________ Date of Birth________________________

Grade:____________ Teacher/Classroom______________________________

Name of Medication ____

Reason for Medication:____

Form of Medication/Treatment:

○ Tablet/Capsule ○ Inhaler ○ Injection ○ Nebulizer ○ Other________________

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

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Start: ○ Date Form Received ○ Other Date:_________________________

Stop: ○ End of School Year ○ Other Date/Duration:________________

Restrictions and/or important side effects: ○ None Anticipated ○ Yes, please describe:

____

Special storage requirements: ○ None ○ Refrigerate

This student is both capable and responsible for self-administering the medication:
○ Yes-Supervised ○ No

This student has such severe reactions that they have physician/parent permission to carry this medication: ○ Yes ○ No

Physician's Name_____________________ Phone Number______________________

I request that (child's name)__________________receive the above medication at school according to standard policy.

I request that (child's name)__________________be allowed to self-administer the above medication at school according to the school policy.

Date:___________________ Parent Signature:___________________________

(This information expires with each school year.)