

St. Charles Borromeo School
Peru, IN

2007-2008 PRESCRIBED MEDICATION PERMISSION FORM

Date received by school _____

Student _____ Date of birth (age) _____

Grade _____ Teacher/Classroom _____

SCHOOL: Please report ANY concerns about medication or disease to the physician listed below.

TO BE COMPLETED BY THE PHYSICIAN or authorized prescriber

Reason for medication _____

Name of medication _____

Form of medication/treatment: Tablet/Capsule _____ Injection _____ Liquid _____
Inhaler _____ Other _____

Instructions (list specific times and dosage given at school) _____

Start date _____ **Stop date** _____

For episodic/emergency events only _____

RESTRICTIONS and/or important side effects: NONE anticipated _____ YES _____

Write clearly on the reverse side of this form *any* specific restrictions.

Special requirements: None _____ Refrigerate _____ Other _____

Please indicate if you have provided additional information, either on back _____ or as an attachment _____

SIGNATURE _____ **DATE** _____

Please print
Physician Name _____

Address _____

Phone Number _____

TO BE COMPLETED BY PARENT/GUARDIAN I give permission for (name of child) _____
_____ to receive the above medication at the school according to standard school
policy. (Medication must be brought in the original container).

SIGNATURE _____ **DATE** _____