



"SOAR LIKE AN EAGLE!"

Medication Permission Form

Student _____ DOB _____
School _____ Grade _____

Policy for students receiving medication at school whether prescribed medication by a physician or authorized prescriber or over the counter medication is as follows:

- Signed orders from the parent/guardian and physician must be on file
- Over-the-counter medication brought in the original container
- Prescribed medication with a pharmacy label that matches the written orders
- All medication must be brought to the school by the parent
- School personnel may refuse to give the medication

To be completed by the Physician or Authorized Prescriber:

Reason _____ for _____ the _____ medication: _____
Name and _____ strength _____ Medication: _____
Form Medication: _____

<input type="checkbox"/> D Tablet/capsule	<input type="checkbox"/> D Liquid	<input type="checkbox"/> D Inhaler	<input type="checkbox"/> D Injection	<input type="checkbox"/> D Other
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Amount and Time/s: _____ For
PRN state the frequency, the time between dosages of medication, and maximum number of dose in a school day: _____

Start date for medication: _____

End date for the medication: _____ (All orders will be valid for the current school year.) Additional information, instructions, restrictions and/or important side effects: _____

Physician or Authorized Prescriber Signature Physician's or _____ Date _____

Authorized Prescriber name (print): _____
Name _____
Phone Number _____ Fax number _____

To be completed by the Parent/ Guardian:

I instruct the school principal or the principal authorized personnel to give the medication as instructed above.

Do you want to be called before or after (circle) a PRN medication is given? Yes _____ No _____

Additional information/instructions or restrictions _____

Consent

I hereby request that the medication specified above be given to the above named student. I understand that the school personnel who give the medication may not be a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the authorized Dr. above, its servants, agents, and employees including, but not limited to the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the authorized Dr. above, its agents, servants, or employees, including, but not limited to the school, the principal, and the individual giving or failing to give the medication.

Parent/ Guardian Signature _____ Date _____

Printed name _____ Relation to the child _____

Special forms is required for severe allergies and administration of Epipens, administration of diabetic medication, and self-



TREZVANT ACADEMY, INC

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administration and carrying of asthma medication.