Permission to Give Medication at School

To Be Completed by Physician

Child's name: ______________________________ Date of Birth: ___________________

Diagnosis:

____

Name of medication:

____

Amount of tablet (in mg): ___________________ or, if liquid (mg/tsp):

____

Or insulin (units):

____

Or Auto-Injector Epinephrine____

Or, if inhaler:

____

☐ Student has asthma; he or she has received instruction in the self administration of his or her asthma medication(s). It is

my professional opinion that he or she **be allowed** to carry and self administer the asthma medication(s).

☐ It is my professional opinion that ___________________________ **should not be allowed** to carry or self

administer his or her asthma medication(s).

Special instructions:

____

____

____

____

Specific times(s) to be administered at school: _________________________

Medication to be taken from (beginning date): ________________ to (ending date): ________________

Are there any restrictions? Yes_____ No _____ If yes, what and how long?

____

____

____

____

Printed name of physician: ____

Physician Signature: ____________________________________ Date: _______________

Thank you for your cooperation,

____ School

Phone____________________________________

School Nurse School Fax #

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