TIPTON ACADEMY

Medication Permission Form

(For all over-the-counter and/or prescribed medications)

Student:_____Date form received:_____

Date of Birth:_____Grade/Teacher:_____

To be completed by the physician:

Name of Medication:_____

Reason for medication (optional):_____

Form of medication/Treatment:

_____Tablet/capsule _____Liquid _____Inhaler _____Injection _____Nebulizer _____Other

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Start: Date form received:_____Other dates:_____

Stop: End of school year:_____ Other date/duration:_____

Restrictions and/or important side affects: _____None anticipated _____Yes (describe below)

Special storage requirements: _____None _____Refrigerate _____Other:_____

The student is both capable and responsible for self-administering this medication:

_____Yes _____Yes-Supervised _____Yes-Unsupervised

Physician name:_____

Address:_____Phone:_____

Date:_____Signature:_____

To be completed by the parent/guardian:

I request that (student name)_____received the above medication at school according to school policy.

I request that (student name)_____be allowed to self-administer the above medication at school according to school policy.

Date:_____Signature:_____Relationship:_____