Carmel Central School District
South Street P.O. Box 296
Patterson, NY 12563

PERMISSION FORM FOR PRESCRIBED MEDICATION

Date form received by the school:_____ Student's Name:_____
Grade:_____ Date of Birth:_____ School_____

To be completed by the physician or authorized prescriber:

Reason for Medication:_____
Name of Medication:_____
Form of medication/treatment: (circle one) Tablet/capsule Liquid Inhaler Injection Nebulizer Other_____
Instructions (schedule and dose to be given at school):_____
_____
Start Date:(please circle): Date form received **OR** Other:_____
Stop Date: End of school year **OR** Other date/duration_____
For episodic/emergency events only
Restrictions and/or important side effects: None Anticipated If Yes, Please describe:_____
_____
Special storage requirements: None Refrigerate Other:_____
_____

This student is both capable and responsible for self administering this medication:*please note, *ALL controlled medication must be kept & dispensed in the nurse's office.*

Please Circle: NO YES-Supervised, by Nurse YES-Unsupervised, once assessed by R.N.
This student may carry this medication: NO YES- again, please note, ***ALL controlled medication must be kept & dispensed in the nurse's office***
Please indicate if you have provided additional information:
On the back of this form As an attachment

DATE:_____ SIGNATURE:_____
STAMP(include address,phone #,License #)

TO THE SCHOOL: Please report concerns about medication or disease to the above physician.

To be completed by parent/guardian

I give permission for (name of child):_____
To receive the above medication at school according to standard school policy.

medication must be brought to the school nurse by parent/guardian and be picked up at end of school year or it will be destroyed

Signature:_____Relationship:_____
Date:_____ Phone:_____Cell:_____Work:_____
nmm/2012