

MEDICATION and PROCEDURE PERMISSION AND INSTRUCTION FORM

Student's Name:	Student's ID #:					
School:	Grade:	Date	of Birth:			
Parent Permission:			•			
I am requesting that my child,or procedures at the time indicated and a	as designated by his/h	ner medical pro	_, receive prescription drugs vider.			
I will be responsible for bringing the pharmacist or druggist. I also understant medication or supplies for procedure a Failure to do this will result in terminal procedure for my child. I understand the procedures, force will not be used by school personnel have permission to coregarding use, side effects, response, and or frequency. I can rescind my permission	d that I am responsib t the school to avoid nation of the school nat, if my child refuse nool personnel to male emmunicate with the	le for maintaini l any interruption l's administration es to take the process we my child con medical provid	ng a sufficient quantity of the ons in the physician's orders. on of the medication and/or rescribed drug(s) or allow the apply. er prescribing the medication			
Signature of Parent/Legal Guardian	F	Relationship	Date: (Mo./Day/Yr.)			
Medication Provided By Parent:						
Name of Medication	Amount		Date			
Medication Returned to Parent:						
Name of Medication	Amount		Date			



Medical Provider Permission

tudent's Name:						
Assigned School:			Grade:		Date of Birth:	
iagnosis: 1				2		
am prescribing the following medi	cation and pr	ocedure	es for the al	ove stu	ident to be ac	dministered or performed at school
aily						
Name of Daily Medication (Generic and Trade Name)	Dosage and Frequency	Time(s	s)	rt date	Stop date	Possible Adverse Side Effect or Contraindications:
RN		I			1	
Name of PRN Medication (Generic and Trade Name)	Dosage and Frequency	and (AM/P		rt date	Stop date	Possible Adverse Side Effect or Contraindications:
						4/
	 					
		1			L	
Procedures Name of Procedure (catheterization, glucose checks, suctioning, etc.):		ge and uency	Time(s) (AM/PM):	Star		Monitoring Parameters
			- 113 year year			T. Comment of the com
he above orders shall be effective throchool year, unless the orders are disco						
Medical Provider's Signat	ture		Date (M	o./Day/Y	(r.)	Telephone/Fax Number
Printed Medical Provider's	N		1			Address