St. Leonard Parish School
Permission Form for Medication Date Received: _____

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Date form received by the school:_____
Student:_____ Date of birth, or age_____
Grade:_____Teacher/Classroom:_____

To be completed by the physician or authorized prescriber
Reason for medication:_____
Name of medication:_____

Form of medication/treatment:
☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (*Schedule and dose to be given at school*):_____
_____

Start: ☐ date form received Other date:_____
Stop: ☐ end of school year Other date/duration:_____
☐ for episodic/emergency events only

Restrictions and/or important effects: ☐ None anticipated
☐ Yes (Please describe) _____
_____

Special Storage Requirements: ☐ None ☐ Refrigerate
Other: _____

This student is both capable and responsible for self-administering this medication:
☐ No ☐ Yes - Supervised ☐ Yes - Unsupervised
This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:
☐ On the back side of this form ☐ As an attachment

Physician's Name: _____
Address: _____
Phone Number: _____
Doctor's Signature: _____

To the school: Please report concerns about medications 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. *(Schools require parent/guardian to bring the medication in its original container.)*
Date: _____ Signature:_____ Relationship: _____

Parent/Guardian Phone Numbers: Home _____ Work _____ Emergency _____