BERKLEY SCHOOLS

Permission Form for Medication Dispensed at School

School:_____ **Date form received by school:** _____

Student:_____ **Date of Birth/Age:** _____

Grade: _____ **Teacher/Classroom:** _____

To Be Completed by the Physician or Authorized Prescriber

Name of medication: _____

Reason for 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 dates: _____

STOP: ○ End of School Year Other date/duration:_____

○ **For Episodic Emergency Events Only**

Restriction / Side effects: ○ None anticipated ○ Yes (please describe) _____

Special Storage Requirements: ○ None ○ Refrigerate ○ Other: _____

Student is both capable & responsible for self-administering medication: ○ No ○ Yes, Supervised ○ Yes, Unsupervised

Student may carry medication on their person: ○ Yes ○ No

Additional Information is provided: ○ On the back of this form ○ As an attachment ○ Not applicable

Physician's Signature_____ **Date** _____

Physician's Name _____

Address _____ **Phone Number** _____

To be completed by Parent/Guardian

○ I request that my child, _____, receive the above medication at school according to standard school policy.

○ I request that my child, _____, be allowed to self-administer the above medication at school according to school policy.

○ I understand, due to the Health Insurance Portability and Accountability Act (HIPPA), that information regarding my child is confidential. To ensure the best outcome for my child, I hereby authorize that medical information regarding my child, _____, may be shared with other school personnel (in addition to his/her immediate teachers)

Signature _____ **Date** _____

Parent Name _____ **Relationship** _____

Return this form to your school office when complete.

BERKLEY SCHOOL DISTRICT ADMINISTRATIVE OFFICES
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