PERMISSION FORM FOR MEDICATION DISPENSED AT SCHOOL
Berkley School District

School: _____

Date form received by the school: _____

Student: _____ Date of Birth/Age: _____
Grade: _____ Teacher/Classroom: _____

To Be Completed By the Physician or Authorized Prescriber

Name of medication: _____

Reason for medication (optional): _____
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 and/or important side 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: ○Yes ○No

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

Signature_____ Date _____

Physician's Name _____

Address:_____ Phone Number_____

To be completed by Parent/Guardian:

○I request that (name of student) _____ receive the above medication at school according to standard school policy.

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

Date: _____ Signature:_____ Relationship:_____

EMERGENCY NUMBERS

Parent/Guardian Cell Phone: _____

Parent/Guardian Work Phone: _____

Name and Phone Number of Friend or Relative: _____ Phone #_____

CONFIDENTIALITY

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).