OUR LADY *of* MOUNT CARMEL
CATHOLIC SCHOOL

OLMC PRESCRIBED MEDICATION PERMISSION FORM

Student: _____Grade: _____Date of Birth: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of Medication: _____

Reason for Medication: _____

Form of medication/treatment: ____tablet/capsule ____liquid ____ injection____

inhaler ____ nebulizer _____ other (please specify)_____

Instructions (list specific times and dosage to be given at school): _____

_____

Start Date: _____ Stop Date: _____

Restrictions and/or important side effects: _____

Physician's Signature: _____ Date signed: _____

Physician's name (printed): _____ Phone: _____

Address: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I give permission for my child, named above medication at school according to standard School policy. Medication must be brought in the original container with child's name, dose & instructions. _____Yes _____ No

I give permission for my child, named above, to transport his/her medication to and/or from school as needed during the school year. _____Yes _____No

Parent/Guardian Signature **Date**

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