



# South-Western City School District

## School Medication Permission and Instruction Form

RN-M003  
Revised: 04/23

School: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

This form must be completed with physician and parent/guardian signatures. The required written information must be received, before any medication can be administered at school AND/OR, if the student is carrying an inhaler/epipen.

### Parent Permission

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

*I hereby request and give permission to the PRINCIPAL or his/her DELEGATE (school nurse or other responsible person) to administer the medication routine described below and to communicate as needed with the prescribing physician. I understand that I am responsible for delivering the prescribed medication to the student's school in its original container (as labeled from the pharmacy) and for assuring that an adequate supply of the medication has been provided to the school.*

If the Health Care Provider has indicated that the student should be permitted to carry an inhaler and/or epipen at school, I understand that the student is responsible for its proper maintenance and use. I understand that if the student is found to have shared his/her medication with other students or otherwise abused the medication or device, the student will not be permitted to carry his/her inhaler and/or epipen at school, and disciplinary action may occur. I understand, and have informed the student, that (s)he must notify the school bus driver, principal, nurse or teacher if his/her inhaler/epipen is lost or is taken from him/her by another person.

Parent Signature: \_\_\_\_\_

### Physician's Direction

*The above named student is under my care and should receive the following.*

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

at these times: \_\_\_\_\_

Other specific instructions for administration:

### Inhaler/Epipen Only:

The student knows and understands the proper use of his/her inhaler/epipen  Yes  No

The student should be allowed to carry it on his/her person.  Yes  No

Possible side effects to watch for:

Expiration date of this request: \_\_\_\_\_

Doctor requests teacher's comments

Yes: Please observe the following:

No: Teacher comments unnecessary

Physician Name (Please print or type): \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

Physician Fax Number: \_\_\_\_\_

Date: \_\_\_\_\_

*STAFF: A copy of this form must be provided to the school nurse if the form is given to any other SWCSD staff member.*