SAU9 Schools

Permission for Medication Administration in School

Childs's Name:_____

Date of Birth:_____ **Grade:**_____

Date:_____ **Teacher:**_____

Diagnosis:

_____

_____

Medication(s) Prescribed: (generic or brand name)

_____

_____

_____

Dosage, Route, Times of Administration, Duration of Treatment:

_____

_____

_____

Modification(s) of School Program:

_____

_____

Side Effects to be Noted:

_____

_____

Student has permission to self carry inhaled asthma medication. Yes___ No___

_____ _____

Physician name printed Physician signature

_____

Physician phone number

I authorize SAU9 School staff to assist my child in taking medication during school hours and agree that I will not hold liable any member of the school staff or and individual in an official capacity designated by the School Administration to assist my child in taking the medication as noted above.

_____ _____

Parent name printed Parent signature

_____

Emergency phone number