Powers Catholic High School

2020- 2021 Permission Form for Prescribed Medications

Student's Name: _____

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

Date form received by school: _____

Name of Medication: _____

Reason for Medication: _____

Form of Medication/Treatment: (circle) Tablet Liquid Inhaler Injection Nebulizer Other

Instructions (Schedule and Dose to be given at school): _____

_____

Start Date: Date form received or Other date: _____

Stop Date: End of School Year or Other date: _____

Restrictions and/or important side effect: _____

Special Storage Requirements: (refrigerate, etc.) _____

The student is both capable and responsible for self-administering this medication:

No Yes (Supervised) Yes (Unsupervised)

This student may carry this medication: Yes No

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Physician's Address: _____

Physician's Phone Number: _____

To be completed by Parent/Guardian:

I give permission for the above medication to be given by the designated Powers Catholic High School employee.

Signature: _____ **Date:** _____

Relationship: _____

*This form is only valid for the current school year. A new form must be filled out every school year.