PLYMOUTH EDUCATIONAL CENTER
PERMISSION FORM FOR PRESCRIBED MEDICATION

Date form received by PEC _____

Student _____ Date of Birth _____

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

Restrictions and/or important side effects: ☐ None anticipated

☐ Yes _____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other _____

This student is both capable and responsible f or self-administering this medication:

☐ No ☐ Yes, Supervised ☐ Yes, Unsupervised

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Date _____ Signature _____

Physician's Name _____
Address _____
Phone _____

To be completed by parent/guardian

I request that _____ receive the above medication at school according to standard school policy.

I request that _____ be allowed to self-administer the above medication at school according to the school policy.

Date _____ **Signature** _____ **Relationship** _____