Holy Family Catholic School
2022-2023 Permission Form for Prescription Medications

Student's Name:_____

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

Date form received by school:_____

Name of Medication:_____

Reason(s) for Medication:_____

Form of Medication/treatment: (circle) Tablet Liquid Inhaler 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 effects: _____

Special storage of Meds (ie: Refrigerate etc.)_____

The student is capable and responsible for self-administration of this medication:

No Yes(supervised) Yes(unsupervised)

The 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 administered by the designated Holy Family Catholic School employee.

Signature: _____ **Date:**_____

Relationship: _____

*This form is only valid for the current school year. Obtain a new form each year or for a new medication/dose change.