# Whitehall Public School District #4, 47, and 2
## Permission Form for Administration of Medications

Date form received by school ______________________

Student__________________________________ Date of Birth_____________________ Age_______

Grade___________ Classroom/Teacher ___________________________________________________

**To be completed by the physician or authorized perscriber if possible:**

Name of medication:___________________________________________________________

Reason for medication:_________________________________________________________

Form of medication/treatment:

_______Tablet / capsule _______Liquid _______Inhaler _______Injection _______Other

Instructions (Schedule and dose to be given at school): ________________________________

Start: ___________ date form received Other date: __________________

Stop: ___________ end of school year Other date / duration: __________________

_______ For episodic / emergency events only

Restrictions and / or important side effects:

_______ None anticipated _______Yes. Please describe _____________________________________

Special Storage requirements: _______ None _______Refrigerate

**Students in grades K-5 may self administer cough drops only**, with a copy of this completed form in the school office. Students in grades 6 – 12 may self administer cough drops, and prescribed and over the counter medication with a copy of this completed form in the school office for each medication. All medication must be in the original container and labeled by a pharmacy. Self-medication is not encouraged but may be appropriate for some students (with asthma, diabetes, or temporarily on antibiotics, for example).

This student is both capable and responsible for self-administrating this medication:

_______NO, please administer from office _______Yes, Supervised _______Yes, Unsupervised

This student may carry this medication: _______NO _______Yes

Physician's Name: ___________________________________ Physician's Phone Number

__________________

**To the School:** Please report concerns about medication or disease to the above physician.

**I give my permission for (name of student) _________________________________________ to receive the above medication at school according to standard school policy. The medication will be brought to school in its original container. In exchange for allowing my child to receive medication at school, I agree to hold the school personnel and Whitehall School District *4, 47,2 safe from all suits and litigation that might occur as a result of the medication administered.**

Signature of Parent/Guardian ___________________________________________

Date______________________

If medication is to be self administered, I agree to take medication as directed in a responsible manner, and to take the medication only myself.
Signature of

Student______________________________________________________Date____________________