PERMISSION FORM FOR PRESCRIBED MEDICATION

St. Andrew Academy
7724 Columbine Drive
Louisville, KY 40258

Date form received by the school:_____
Student_____Date of Birth_____Age____
Grade_____ Teacher/Classroom_____

To be completed by an appropriate healthcare provider.
Reason for medication_____
Name of medication_____

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 Date_____
Stop _____ end of school year Other date_____
_____for episodic/emergency events only

Restrictions and/or important effects:
_____None anticipated
_____Yes: Please describe _____

Special Storage Requirements: _____None _____Refrigerate
Other _____

Physician's Name_____
Address:_____
Phone Number_____
Doctor's Signature_____

To the school: Please report concerns about medications or disease to the above physician

To be completed by Parent/Guardian
I give permission for (name of child)_____to receive the above medication at school according to standard school policy. (School require parent/guardian to bring the medication in its original container.)

Date:_____Signature:_____Relationship:_____
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Parent / Guardian Phone Numbers:
Home_____Work_____Emergency_____

Student Name/ Homeroom:_____Date:_____