

PERMISSION FORM FOR PRESCRIBED MEDICATION

Albion Elementary School
324 East Avenue
Albion, New York 14411
Fax: 585-589-2059

Albion Middle School
254 East Avenue
Albion, New York 14411
Fax: 585-589-2029

Albion High School
302 East Ave
Albion, New York 14411
Fax: 585-589-2049

TO BE COMPLETED BY PARENT/GUARDIAN:

Student: _____

Date of Birth: _____ Grade: _____

I give permission for (name of child) _____ to receive the medications, listed below, at school according to standard school policy and as ordered by my health care provider. (The Albion Central School District requires parents/guardians to bring the medication to school in its original container.) I also give permission for photos to be taken of my child to be used on the medication log.

Date: _____ Signature: _____ Relationship: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for medication: _____

Name of medication: _____

Form of medication/treatment:

____ Table/Capsule ____ Liquid ____ Inhaler ____ Injection ____ Nebulizer ____ Other _____

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

Start: ____ Date form received ____ Other date: _____

____ End of school year ____ Other date/duration: _____

____ For episodic/emergency events only

Restrictions and/or important side effects:

____ None expected

____ YES, Please describe: _____

Special storage requirements: ____ None ____ Refrigerate

Other: _____

Self Medication: Inhalers & Epi-pens ONLY:

The above student has been instructed in and understands the purpose, appropriate method and frequency of use of the following medication. He/she should be permitted to carry the medication on his/her person or to keep named medication in his/her locker or physical education locker, as we consider him/her responsible.

Name of Medication: _____

____ Please indicate if you have provided additional information as an attachment

Date: _____ Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

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