The Lillian and Betty
Ratner School

WHERE EACH CHILD THRIVES

MEDICATION PERMISSION FORM

Student: _____ Grade: _____ Date of Birth: _____

Address: _____ Phone: _____

TO BE COMPLETED BY PHYSICIAN

Date: _____ Name of Medication: _____

Reason for Medication: _____

Form of Medication/Treatment:

❑ tablet/capsule ❑ liquid ❑ inhaler ❑ injection ❑ nebulizer ❑ other

Instructions:
Dose: _____ Frequency:_____ Time(s) to Administer:_____

Start Date: _____ Stop Date:_____

Side Effects: _____

Restrictions: _____

Special Storage Instructions: _____

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____ **Phone:** _____

Physician's Address: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I GIVE PERMISSION FOR MY CHILD_____TO RECEIVE MEDICATION AT SCHOOL ACCORDING TO SCHOOL POLICY AS INSTRUCTED BY THE PHYSICIAN AND AGREE TO THE FOLLOWING:

❑ to deliver medication to school in the original container.
❑ to have a new form completed by the physician if medication or dosage is changed or discontinued.
❑ to notify the school if we change physicians.

Parent's/Guardian's Signature: _____ Date:_____

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