Birmingham PUBLIC SCHOOLS Achievement Character Community

Permission to Administer Medication

Date _____

Pupil _____ B.D. _____ Grade ____ School _____
Last First M.I.

Attending physician _____ Telephone _____

Physician's address _____

Physician's fax _____

MEDICATION

Name of medications _____ Dosage _____

Time of administration _____ Reason for medication _____

Start _____ Stop (end of school) _____ Other _____

Comments/Possible side effects

_____

_____

_____

Name of medications _____ Dosage _____

Time of administration _____ Reason for medication _____

Start _____ Stop (end of school) _____ Other _____

Comments/Possible side effects

_____

_____

_____

Physician:

If student requires an Epi-pen, TwinJet or inhaler, and a second Epi-pen, TwinJet or inhaler is required for bus transportation, please provide an extra prescription to parent so they can provide the addition pen

Physician's signature _____ Date _____

To be completed by parent

I hereby request that my child be administered prescribed medication at school by school personnel. I understand that the medication will be administered exactly as per directions of my above-named physician. I will notify the school of changes or discontinuance of this medication(s) by completing a new form.

Signed _____ Date _____
Parent/Legal Guardian

Address _____

Revised 6//23/09