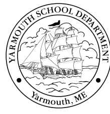

YARMOUTH
SCHOOL DEPARTMENT

"Empowering students"

Andrew R. Dolloff, Ph.D.
Superintendent of Schools

Jodi McGuire
Director of Instructional Support

Herbert Hopkins
Director of Business Services

MEDICATION PERMISSION FORM

MEDICATIONS MUST BE BROUGHT TO SCHOOL IN THE **ORIGINAL CONTAINER BY THE PARENT/GUARDIAN.** (Pharmacies will provide an extra container if needed) NO MEDICATION will be administered without this information.

Student's Name: ______________________________ Grade:_____ Teacher:______________

Name of Medication: _________________________________ Dose: ____________________

Reason for Medication: ____________________Time(s) need to be given: ________________

____Tablet/capsule ____Liquid ____ Inhaler ____Injection ____Nebulizer

Start on date (____/____/____) Stop on date (____/____/____)

Restrictions and/or possible side effects: _____ None anticipated _____ Yes, please

describe ____

Permission to contact prescribing physician:
I gave my permission for the school to contact the above named prescribing physician to obtain information about medication and the administration schedule.

I understand the the above medication may be administered by the school nurse or an unlicensed staff member designated by the principal as allow by law. The school may refuse any requests not in compliance with school policy.

Medication Removal:
At the end of the school year or the last student day, I understand that I must pick up my child's medication or it will be discarded.

Parent/Guardian signature: ___________________________________ Date: ___________

Prescribing provider's name: ____

____ __________________________
medical provider's signature Date

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