DEPARTMENT OF SPECIAL EDUCATION AND STUDENT SERVICES
CHARLOTTESVILLE CITY SCHOOLS
CHARLOTTESVILLE, VIRGINIA

PERMISSION FOR MEDICATION

Name of student:_____DOB: _____

School: _____Grade: ____

Teacher/Homeroom: _____

Medication and dosage: _____

_____

Purpose of medication: _____

Time of day medication is given:_____

Possible Side Effects:_____

_____

Anticipated number of days medication needs to be given: _____

Name of Physician:_____Phone: _____

Physician Signature: _____

I hereby give permission for _____ to take the above
(student's name)
named medication at school as prescribed. I understand it is my responsibility to furnish this medication.

_____ _____
Print Parent /Guardian Name/Date Daytime Phone Number (s)

_____
Parent/Guardian signature

* PERMISSION TO CARRY INHALER AT ALL TIMES DURING SCHOOL DAY

NOTE: **The prescription medication is to be brought to school in a container clearly labeled by the pharmacy or the physician, stating the name of the student, the name and dosage of the medication, and the name of the physician.**

FAX Number: _____