PORTLAND CHRISTIAN SCHOOL

Permission Form for Prescribed Medication

Student Name: _____ Grade: _____

Date of Birth: _____ School Year: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of Medication: _____

Reason for Medication: _____

Dosage: _____ Route: _____

Specific time for administration: _____

If PRN, frequency: _____

Medication administered:

Start: □ Date form received □ Other, as date specified: _____

Stop: □ End of school year □ Other, as date specified: _____

Physician's Name: _____

Physician's Signature: _____

Address: _____ Phone #: _____

******* FOLLOWING SECTION IS FOR SELF-ADMINISTRATION OF MEDICATION ONLY******

Portland Christian School permits a responsible, trained student to carry and/or self-administer medication for asthma, diabetes, or an anaphylactic reaction on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, and school approval.

This student has been trained on self-administration of this medication? **(For asthma, diabetes, or severe allergy ONLY)** □ NO □ YES

May this student carry and self-administer this medication?

□ NO □ Supervision required □ Supervision not required

Physician's Signature: _____ Date:_____

*Please complete one form per medication. Form expires at end of school year.

Parental Consent

I hereby acknowledge that if this medication is not self-administered, it may be given by unlicensed PCS staff. By signing this form, I hereby release PCS and its employees from any liability that may occur from the administration of this medication according to physician's instructions.

Also, I hereby give consent for the health care provider completing this form to discuss the medication administration and medical condition being treated with PCS staff.

_____ _____ _____

Name of Parent/Guardian (please print) Signature of Parent/Guardian Date

TO BE COMPLETED BY SCHOOL PERSONNEL

Form received by: _____ Date Form Received: _____

School Year: _____