Saint Brigid Catholic School
After School Care Program
Permission Form for Prescription Medication

Student Name: _____
Student Date of Birth or Age: _____
Student Grade Level: _____
Student Teacher/Classroom: _____
Date Form was Received: _____

Name of Medication: _____

Reason for Medication (optional): _____

Form of Medication/Treatment: _____Tablet/Capsule _____Liquid
_____Inhaler _____Injection _____Nebulizer Other: _____

Instructions (schedule and dose to be administered on site): _____

_____

Start: _____ Date form Received:_____ Other dates: _____
For Episodic/emergency events only Other date/duration: _____
Stop: _____End of Program Year

Restrictions and/or important side effects: _____None anticipated _____Yes

Please describe _____

Special storage requirements: _____None _____Refrigerate _____Other _____

Physician's Name: _____
Address: _____
Phone Number: _____

To be completed by parent/guardian:

I request that (name of child) _____receive the above medication during school time according to the standard policy.

_____ _____ _____
Signature Relationship Date