Birmingham PUBLIC SCHOOLS Achievement Character Community

Permission to Administer Medication

Date_____

Pupil _____B.D. _____Grade _____School _____
Last First M.I.

Attending Physician(s)_____

Physician's address _____

Physician's Telephone _____ Fax _____

MEDICATION(S): (**Must be in original packaging**)

(1) Name of medication_____Dosage _____

Time of administration _____**Reason** for medication _____

Start_____Stop (end of school) _____ Other _____

Comments/Possible side effects

_____

_____

_____

(2) Name of medication_____Dosage _____

Time of administration_____**Reason** for medication _____

Start _____Stop (end of school) _____Other _____

Comments/Possible side effects

_____

_____

_____

Physician: **(**Physician's signature **required** for **prescription** medications to be administered**)**

If student requires an Epi-pen, TwinJet or inhaler, plus an additional Epi-pen, TwinJet or inhaler required for bus transportation, please provide an **extra** prescription to parent so they can provide the addition pen.

Physician's signature_____Date_____

Physician's signature for self carry/self administration of EpiPen/Inhaler _____ Date_____

Parent/Legal Guardian:

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.

Parent/Legal Guardian's signature**:**_____Date _____

Address _____

E-Mail_____Cell Phone _____