

# Montgomery County Public Schools

## Medication Permission Form

We appreciate your help in avoiding the administration of medication during school hours. Whenever possible please have medication given at home, before or after school. Please complete a separate form for each medication to be given during school hours, on field trips, and/or after school activities.

Name of Student (Last, First, MI):		Student's Date of Birth (M/D/Y):
School:	Grade:	Teacher:
Allergies:		
Medication:		
Dosage:	Form/Route of Administration:	Time(s) of Administration:
If Medication to be given "when needed" describe indications and how often it can be repeated:		
List significant side effects/adverse reactions to be reported to doctor:		
Student is able to self administer medication: Yes _____ No _____ <i>(Emergency medications and/or grades 9-12 ONLY-See #5 and #6 on Administrative Procedures for Administering Medications to Students).</i>		
Student authorized to carry own inhaler: Yes _____ No _____		
Start Date:	End Date:	In addition, this medication <b>must</b> be taken on a: (Circle all that apply) <i>Field trip, After school activity, Overnight field trip, Does not apply</i>

***A licensed prescriber's signature is required for all prescription medications.***  
***This signature is also required for non-prescription medications to be given more than 3 consecutive days.***

Date:	Physician/Licensed Prescriber Signature:
Phone:	Address:

I request that authorized school personnel assist my child in taking the medication(s) described above while at school. I have read and accept the procedures listed in this manual. I authorize a representative of the school to share information regarding this medication with the licensed prescriber signing above. I understand that MCPS Board and its employees are not responsible for the effects of the medication administered.

Date:	Parent/Guardian Signature:
Home Phone:	Work Phone:
Emergency Phone/Contact Person:	