ELYSIAN CHARTER SCHOOL

STUDENT_____Age_____Grade_____Teacher_____

To be completed by the physician or authorized prescriber,

***NO MEDICATION CAN BE GIVEN WITHOUT THE PHYSICIAN'S SIGNATURE BELOW.**

Reason for medication:_____

Name of medication:_____

Generic name of medicine:_____

Form of medication/treatment:

_____Tablet/capsule_____Liquid_____Inhaler_____Injection_____Nebulizer_____Other

Instructions (Schedule and dose to be given at school:)_____

_____

Start:_____Other date:_____

Stop:_____Other date/duration_____

_____for episodes/emergency events only

Restrictions and/or important side effects:_____None anticipated

_____Yes. Please described_____

_____Special Storage

Requirements: _____None _____Refrigerate

FOR ASTHMATIC INHALERS ONLY

This student is both capable and responsible for self-administering this medication:

_____No _____Yes, Supervised _____Yes, Unsupervised

This student may carry this medication: _____No _____Yes

Please indicate if you have provided additional information:

_____On the backside of this form _____As an attachment

Date_____ **Physician's Signature**_____

Physician's Name:

Address:

Phone Number:

***Physician's Signature**_____

To the school: Please report concerns about medications or disease to the above physician.

To be completed by the parent/guardian:

I give permission for (name of child)_____to receive the above medication at school according to standard school policy.

(all schools require parents/guardians to bring the medication in its original container)

Date: _____Signature: _____Relationship: _____