2020/2021

Permission Form for Prescription Medication

First Name ______________________ Last Name ______________________
Date __________________ SSN __ __ __-__ __-__ __ __ __ Sex: ☐ M ☐ F

Saint Louis
COUNTY
HEALTH

*All information required

To be completed by Child's Physician or Authorized office personnel:

Diagnosis ____
Name of Medication: ________________ Starting Date____________ End Date ______________
Form of medication/treatment (circle): Tablet/Capsule Liquid Inhaler Injection Nebulizer
Other____
Dosage ____________________________________ Time(s)____________________________
Special Instructions ____
____
Restrictions and/or side effects associated with Medication ____________________________
____
Physician's Signature ______________________________________ Date ___________________
Please Print Name ____________________________________ Address _______________________

To be completed by the Parent/Guardian

I give permission for (name of child) _____________________________ to receive the above medication at school according to the school's policy.
Signature of Parent/Guardian ___________________________________ Date _________________

Note: Medication must be in its original container.

Record of Administration of Medication

Staff Name	Date	Time	Dosage

Note: Medication must be in its original container.

Please return completed forms into the TSMSOC school office

6345 Wydown Blvd. Clayton, MO 63105 ph 314-721-4422 fax 314-721-4448

2020/2021

Permission Form for Non- Prescription Medication

First Name ______________________ Last Name ______________________
Date __________________ SSN __ __ __-__ __-__ __ __ __ Sex: ☐ M ☐ F

*All information required

To be completed by the Parent/Guardian:

Name of Medication: _________________ Starting Date_____________ End Date ________________
Form of medication/treatment (circle): Tablet/Capsule Liquid Inhaler Injection Nebulizer
Other____
Dosage ______________________________________ Time(s)_______________________________
Special Instructions ____
____
Restrictions and/or side effects associated with Medication ____________________________
____
Signature of Parent/Guardian _______________________________________ Date _______________

Note: Medication must be in its original container.

Record of Administration of Medication

Staff Name	Date	Time	Dosage

Note: Medication must be in its original container.

Please return completed forms into the TSMSOC school office

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