Osage County R-1 School District
Chamois, Missouri

ADMINISTRATION OF MEDICATIONS TO STUDENTS
(Permission Forms for Medications)

Please attach any additional information the district might need to have in an emergency

Student's Information

Name_____ Age _____ Date of Birth _____

School/grade level: _____Chamois Elementary _____Chamois High School

Medication/Prescription Information

☐ Prescription Medication ☐ Over-the-Counter Medication Provided by Parent/Guardian

Has the student been given the first dose of this medication? ☐ Yes ☐ No

Name of Medication_____

Reason for Medication_____

Form of Medication/Treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler
☐ Injection ☐ Nebulizer ☐ Other_____

Describe the schedule and dose to be given at school_____

If an "as needed" medication, indicate the maximum dosage per day_____

Are there any restrictions and/or important side effects: ☐ Yes ☐ No

If yes, please describe:_____

_____

_____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other_____

Physician's Information

Physician's Name_____

Address_____

Phone number_____ Fax _____

Physician Signature_____

(required for medications given for more than an "as needed" basis or medications needed on a regular/scheduled basis)