St. Dominic School
Permission Form for Prescribed and Over-the-Counter Medication

Phone: 251-1276 Fax: 251-6428

Student_____ Date of Birth_____

Homeroom_____ Teacher_____

Address_____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for Medication_____

Name of Medication_____

Instructions (schedule & dose to be given at school)_____

Inhaler/Epipen to be carried by student? Physician, please check Yes_____ No_____ and sign.

Physician's signature for student to carry Inhaler/Epipen_____

Date Medication to start_____ Date Medication to stop_____

Restrictions and/or important side effects_____

Date_____ **Physician signature:**_____

Physician's Name_____ Phone_____

Physician's Address_____ Fax_____

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. I agree to hold employees and the Board of Education free from all responsibility for results of such medication.

My child_____ is to eat lunch at the food allergy table: Yes_____ No_____

Signature_____ Date_____

Phone_____ Relationship_____

THE STATE OF OHIO REQUIRES THAT MEDICATION BE BROUGHT TO THE SCHOOL NURSE IN THE ORIGINAL CONTAINER.