



Bentonville Schools
Health Services

PERMISSION FORM FOR PRESCRIBED MEDICATION

Student Name: _____ **DOB** _____
Grade: _____ **School:** _____
School Year: _____ **Teacher/Homeroom:** _____

In order to help protect your patient, your written authorization is required for the student to receive the medication listed below in the school setting. This medication is given to maintain or improve health and therefore benefit from school attendance.

Please contact the school RN if there are any questions at: 479 _____.

The parent may return this form to the school nurse or Fax this form to: 479 _____.

To be completed by Arkansas Physician or Prescribing Medical Professional

Name of Medication: _____

Instructions: (Schedule to be given during school hours)

Dose _____

Time(s) _____

Diagnosis/Reason for Medication: _____

Form of medication/treatment:

____ Table/capsule ____ Liquid ____ Inhaler ____ Injection ____ Nebulizer ____ Other: _____

Start Date: ____ When Forms/Meds received ____ Other, as specified: _____

Stop Date: ____ End of school year ____ Other date/duration: _____

____ FOR EPISODIC/EMERGENCY EVENTS ONLY

Restrictions and/or important side effects: ____ NO restrictions
 if YES-Please describe: _____

Special storage requirements: ____ None ____ Refrigerate ____ Other: _____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____

Phone: _____

E-mail: _____