REGIONAL OFFICE OF EDUCATION

(720.14F)

Permit for Authorized Personnel
To Administer / Distribute
Required Medication During School Hours

Student's Name _____ School _____

(TO BE COMPLETED BY PHYSICIAN)

NOTE: THE REGIONAL OFFICE OF EDUCATION PERSONNEL WILL ONLY ADMINISTER / DISTRIBUTE THE FOLLOWING TYPES OF MEDICATION: ATTENTION DEFICIT DISORDER, ASTHMA, SEIZURE AND DIABETIC MEDICATIONS.

Date: _____

This student _____ is under my medical care for

_____, and medication is required

during the school day for the purpose of _____ .

Name of Drug	Dosage	Frequency	Time To Be Given At School	Duration	Side Effects

- School Use Only -

Approved: Yes _____

No _____

_____
Building. Administrator Date

Signature of Physician _____

Printed Name of Physician _____

Address _____

_____
(City) (State) (Zip Code)

_____
Emergency Telephone Number

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I, _____, give permission for my child to receive the above medication(s) as directed by the physician. The medication will be sent to school in a container appropriately labeled by the pharmacy. I will notify the school in writing if the medication is discontinued. Also, I will obtain a written doctor's order if the medication dosage is changed. I will bring the medication to the school administrator or designee.

Date: _____ Parent's Signature _____

Telephone #: _____ Address _____

Approved: 07/01/01 _____

(City) (State) (Zip Code)