

**MEDICATION PERMISSION FORM  
MALCOLM PUBLIC SCHOOLS**

The providing of medication at school is strongly discouraged except when necessary for the student's health or education. The dosage intervals of many medications can be adjusted so the times for taking the medication come outside school hours. When possible, interval adjustment should be considered before bringing medication to school. All medications provided by school district personnel shall be administered in accordance with the Medication Aide Act. If the physician and parent determine that the student may self provide his/her own medication, you may send one day doses, with the medication permission form completed. Prescription medicine **MUST** be in the original bottle, with dosage, student's name, current date, time to be administered and physicians name. Non-prescription medications shall be provided to the student **ONLY WITH WRITTEN DIRECTIVE FROM PHYSICIAN** and the medication sent from home.

**Medication Permission**

I \_\_\_\_\_ do give permission for the Malcolm School to provide  
(name of parent/guardian)

\_\_\_\_\_ to my child \_\_\_\_\_. This medication  
(name of drug) (child's name)

is to be provided at \_\_\_\_\_(time) on \_\_\_\_\_(dates).

**CHECK ONE OF THE FOLLOWING:**

\_\_\_\_ Medication may be self-provided by the student, and the student is competent to self-provide medication. We, student, parent and physician have developed a plan for self provision of the medicine, storage of medicine, and a plan for reporting that is deemed safe and appropriate, and if applicable authorize the use of hypodermic syringes and similar medical items.

\_\_\_\_ Medication may NOT be self-provided by the student, and the student is NOT competent to self-provide medication. We, student, parent and physician would like to have a school personnel store, provide and watch the student take his/her medication. The school does NOT provide any staff to administer injections of any kind.

I hereby release the School District of Malcolm and the Board of Directors of the School District and all employees, agents, and representatives of the School District from any liability concerning the providing or non-providing of the medication to the student. I accept ultimate responsibility for monitoring the effects of this medication.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Parent/Guardian Signature

Phone Number

\_\_\_\_\_

\_\_\_\_\_

Signature of Physician (for NON-prescription drugs)

Phone Number

\_\_\_\_\_

\_\_\_\_\_

