

CUMBERLAND SCHOOL DEPARTMENT

LONG TERM MEDICATION

I give permission for _____ at _____
(Name of Student) (Name of School)

DOB: ___/___/___ Grade: ___ to receive _____ as ordered below.
(Name of Medication)

Dosage to be administered: _____ Route: _____

Time to be administered: _____ Reason for Medication: _____

Duration: From: _____ to: _____
(Start Date) (End Date)

Possible Side Effects: _____

Does the school nurse/teacher have permission to release this information to school personnel who may have a need to know (i.e.: teacher, principal)? **YES** **NO**

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

Physician's Phone: _____ Physician's Fax: _____

Parent's Signature: _____ **Date:** _____

PERMISSION TO SELF-CARRY/SELF-ADMINISTER MEDICATION:

Please circle INHALER EPI-PEN INSULIN OTHER: _____
medication (specify)

I have instructed _____ in the proper use and administration of his/her medication. It is my professional opinion that he/she should be allowed to carry and use this medication by himself/herself.

It is my profession opinion that _____ should not self-carry or self-administer his/her medication.

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

Parent's Signature: _____ **Date:** _____